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ABSTRACT

This report compiles the proceedings from the third national forum of the Canadian Child Care Federation, held in November 2001, which provided an opportunity for early childhood educators, practitioners, and researchers to share knowledge, learn from each other, and network with colleagues. The agenda included 4 keynote speeches, 30 workshops on current Canadian early childhood research, and a national panel of the directors of the Centres of Excellence for Children's Well-Being. The topics for the keynote addresses are: working together for children and youth, enabling conditions for healthy child development, society and developmental health, and the sacredness of life. Workshop topics include child abuse and neglect, the impact of low income/poverty on child development, public policy related to children, government-voluntary sector collaboration, prenatal influences, mental health services, how research is linked to practice in various locations in Canada, middle childhood and adolescence, nutrition issues, youth engagement, child health, and the first year goals and activities of the Centres of Excellence for Children's Well-Being related to early child development, child- and youth-centered prairie communities, child welfare, youth engagement, and children and adolescents with special needs. (KB)

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ED 475 182

Linking Research to Policy and Practice for Children & Youth

THIRD CANADIAN FORUM

NOVEMBER 22 – 24, 2001

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PROCEEDINGS REPORT

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Linking Research to Policy and Practice for Children and Youth
Third Canadian Forum

November 22 – 24, 2001

Proceedings Report

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Introduction

The Canadian Child Care Federation (CCCF) is pleased to present the proceedings report from *Linking Research to Policy and Practice for Children and Youth: Third Canadian Forum*, held November 22-24, 2001 in Ottawa Ontario. The forum was co-sponsored by the CCCF, the Canadian School Boards Association (CSBA), the Centre of Excellence for Early Child Development (CEECD) and Health Canada.

Almost 400 educators, practitioners, researchers and policy makers from across Canada gathered to share knowledge about current Canadian research and practice related to children's well-being. The agenda included four inspiring keynote speakers: Ken Dryden, Judith Maxwell, Daniel Keating and Cherry Kingsley. The five directors of the Centres of Excellence for Children's Well-Being presented their first year's goals and activities. Two-thirds of the thirty-odd workshops gave delegates a taste of the work in which the centres of excellence are engaged.

This third forum gave researchers, policy-makers and practitioners opportunities to connect with one another and to exchange ideas and information. In one participant's words, the forum was "Great brain food! An exceptional learning experience!"

The participating organizations would like to acknowledge the contribution of their staff, without whom the forum would not have been possible. We are grateful to Health Canada, Human Resources Development Canada and the Centre of Excellence on Early Childhood Development for their support for this proceedings document. And finally, we thank the presenters, whose research – and willingness to share that research – enriches and strengthens the work of all who work with and for young children in Canada. This volume includes only the work of those workshop presenters who provided a summary document.

The print version of the proceedings is being distributed to the regular distribution list of *Research Connections Canada*: children's organizations, government child care departments and post-secondary institutions offering Early Childhood Care and Education programs. A limited number of paper copies of this document are available for purchase at $35.00 each. Contact the Canadian Child Care Federation, 383 Parkdale Avenue, Suite 201, Ottawa, Ontario K1Y 4R4. Phone (613) 729-5289 or 1-800-858-1412 ext. 234; fax (613) 729-3159; email orders@cccf-fcsge.ca; website www.cccf-fcsge.ca. A CD-ROM format of the proceedings is being sent to all delegates at the Forum. Extra copies are available at the above address. For information about a particular presentation, please contact the person listed at the end of each workshop summary.

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- Centres of Excellence for Children's Well-Being
  www.hc-sc.gc.ca/hppb/childhood-youth/centres/index2.html

KEYNOTE

Working Together for Children and Youth

by Ken Dryden

My office is on the 5th floor at Air Canada Centre. When I look out the windows - which I do as often as possible – to my left are the train tracks that lead in and out of Union Station, and the skyline of downtown Toronto. To my right is the traffic of the Gardiner Expressway, some waterfront condos and office buildings. And in recent weeks, when I glance up and see a plane still about 100 feet in the air coming in from the east in its final approach to the Island Airport, I do an emotional double-take. The plane looks to me as if it's flying straight into the side of the Toronto Star Building.

A lot has changed since September 11th.

It is hard to find words. Commentators we trust, no more experienced in this than we are, sound just as dumb and trite as we do. "The world has changed forever," we say and hear again and again. Though I'm not sure it has. Forever is a very long time. I don't know that I'm still feeling the effects of Pearl Harbor or the Kennedy assassination. Maybe I am. But other things always seem to come up and distract me on to something else. I think we want the world to have been changed forever. It should be. Surely, life just can't go on as if nothing has happened. Surely, we can't be that jaded, that superficial, that inhuman. If this tragedy doesn't do it, what will?

Yet in most visible ways, life isn't much different. I still get up at the same time; go to bed at the same time. The pattern to my days hasn't changed. I eat the same foods; work in the same place, with the same people. I dream the same dreams. It's only when I travel, which most days I don't, that I notice anything concrete.

But life is different. It feels different. It feels less spontaneous. I just can't go wherever I want, whenever I want. How long will security at the airport take? What about the line-ups at the border? Maybe I shouldn't go. Maybe I should call family-members before I leave and when I get back. Otherwise, they'll worry. Three months ago, I had my old world figured out. Now, I have a new one to learn.

But more than the patterns, it's the new assumptions. I grew up always assuming I was OK. I'm well. I'm fine. And on those days when I'm not, I shrug and say "I will be."

I assumed that armies, policemen, judges, parents and laws protected me, but that human understandings, the Golden Rule, protected me far more. I assumed that no one was out to get me. That if I paid some attention to where I was and when I was there, that nobody would want to hurt me. That I was safe.

I assumed trust. The world I lived in was based on trust, built on trust. I needed to believe that when I got up in the morning, everything somehow would be OK. That I could just get on with my life. I could just live.

What happens when we begin to assume that box cutters aren't really box cutters; that laptops might be bombs? When anything might be a weapon, and anyone might be an enemy? When every white powder we see makes our stomach flip? When every time we turn on the news, we feel dread? What happens when we begin to feel that anyone can kill any of us anytime he wants to? When almost anything can happen? And what happens when knowing all this makes us afraid? When we decide not to do this, and stop doing that?

And what happens when we begin to fight back? When we re-prioritize, redeploy, spend and spend to make ourselves secure? When we write new laws, crack down, scapegoat, wave the flag, sing proud songs and orchestrate a single mind just to get us through the day? What happens when the psychological, financial and human cost of coping fundamentally, dangerously changes our lives? What happens then?

Maybe we'll all get used to it. Then life won't feel different. Then life will only *be* different. Today, our challenge is to find a way to cope with the aftermath. And for today, that's OK. But very soon, it will be time to think of the future. Is this as good as we can do? Is this as good as life gets? And what about our children? Do they need to live the life that we've created?

How can our kids do better?

Like you, I've wondered about this for a long time. I've wondered about it since our own kids were born. Since I was Youth Commissioner in Ontario when my job was to find employment, training, hope – something – for 140,000 unemployed youth, many of whom had dropped out of school. I've wondered about it since I spent a year in a high school classroom trying to understand why some kids learn and others don't. I don't know the answer, but I think now I know where to begin to find it. And it's time we all started looking.

I don't believe there's a single politician today anywhere in the world who wouldn't champion a major initiative for children and youth. I also don't believe there's a single citizen who wouldn't applaud that. The problem of doing better is not an absence of will. It's an absence of way. Simply, how do we go about doing it? What would the program look like? How would it work? Does it work? And how do we know? We put a program into place. It works, we're told again and again. Every program works. Why then aren't our kids doing better?

We don't do better for kids because I don't believe enough citizens and politicians believe there's a major initiative for children and youth that will work.

Putting a human face on statistics

First of all, we need to know how our kids are really doing. Compared to last year; compared to kids in other countries. We need to know what all the information we've gathered and all the research we've done adds up to. And we need to put a human face on it. Statistical findings won't do that. Drugs or alcohol taken by a mother during pregnancy can kill brain cells and inhibit growth in an unborn baby. What does this mean to the child once born? Why does it matter if some of their functions develop more slowly? They've got so many years ahead of them to catch up. But if they start behind, if they can't quite do what other kids their age are doing, how does that make them feel? How do other kids treat them? How do their own parents treat them? How do they come to see themselves? What do they come to expect, and hope for in life? What do they dream? What is life like for that child at age 5, and 10, and 20?

What about child poverty? I can imagine its hunger and dirt and cold, but how does that affect how a child learns and develops? Put me inside that kid's skin. Tell me about early childhood education. We live so many years afterwards; we experience so many more things. We are capable of doing so much more as we get older – why should it matter those first few years of life? I want to understand. I *need* to understand if I'm going to care enough to want to do something about it. Don't tell me the whats: child poverty is bad; early childhood education is good. Tell me the whys! That's where the "aha" of recognition lies, the anger, the resolve – that's where the power of the information lies. Don't tell me unconnected stuff. Tell me a story.

With a story, I discover a person. Then I see what I know and I see what I don't. I see the consequences of roads not taken. I begin to imagine possibilities and see priorities. I understand what's coming next. I get excited. I rediscover a will. I discover the beginnings of a way. We need that story told and we need it told again, year after year. We need an annual story on the state of Canadian youth.

It can seem a modest step but it isn't. It will serve as a reference point. It will focus debate, help establish priorities, direct research, offer the standard and challenge, generate public and political will. It is the step that leads to other steps and gives them all a chance. And it's the best way I can think of to pull our communities together to serve children. It puts the focus on kids and their needs, not on organizations and their needs; it puts the focus on what we have in common, not on what we don't.

But a good story needs a good storyteller. A national Youth Commissioner with the mandate and standing to tell the story and keep on telling it across the country in ways people understand. It might be a Youth Commissioner similar to the model others have suggested. Or, it might be one that has few other powers than to tell this annual story. Nothing should allow the debate over the creation of the position to become so distracted and confused by jurisdiction and turf that the essential why gets forgotten. What if no position is created, and nothing gets done? And kids don't do better? A story exists above jurisdiction; beyond turf. Its only power is in what it says. Its only influence is what it earns and deserves.

What makes youth different?

I think that we also need something else. Almost a year ago, I was asked to work on what I was told was a secret project. I had worked on secret things before, I guess, but they were so obviously secret, I didn't think of them that way. This one didn't, so I didn't take that part of it very seriously. Until one day, with a friend, I alluded to the project, and the next day that conversation was reported back to me – with a slap on the wrist.

The project had to do with Toronto's 2008 Olympic bid. Beijing was clearly the frontrunner. All the logistics for the venues for all the bids had been laid out and presented to the IOC. Was there anything Toronto could do to swing the vote at the end? To offer something that

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would symbolize the spirit of Toronto's bid? To be Toronto's and the Olympics' gift to the world, long after the Games were over?

The idea was for a world youth centre. The original approaches suggested were very traditional. They would generate a youth centre based on very adult understandings. I had seen that too often before, I said to the organizers. Every youth conference I'd attended, every adult conference that had youth delegates, had always been the same. Financed by adults, its messages intended for an adult audience, the youth present were like mini-adults. They talked like adults, thought like adults, they had been noticed and invited precisely because they were so adult-like.

These youth were adult prodigies, like piano or sports prodigies, kids who could do adult things at a freakishly youthful age. Not as well as adults could do them, but being so young, it never seemed that way. At these conferences, adult opinion was challenged. Mini-adult opinion was not. It was accepted as the voice of God, and delivered with the same disturbing certainty. The result was rarely useful.

I said to the Toronto organizers that I'd like to be involved in the project, but only if it was a true youth centre. I wasn't quite sure what that would mean; I was more sure what it didn't. But that was the challenge. What is it about youth that is different from adults?

More than adults, kids take their world as it is. They have no context. They don't see themselves as rich or poor. They just are. They need help to survive; so they accept help. Whatever they get is good; whatever they don't get, they don't notice. They trust because they have to trust. They do because they are able to do. Aware of new things, they try new things. Experience new things. They learn. They accept and trust and do and try, unless they learn otherwise.

As kids get older, they become more aware. But with their world offering up so many new things, there is always so much new to try. New ways to move their body; new ways to stretch their mind. We think of youth as a time to explore and risk – to push farther, be wilder and crazier. To experiment, take chances, fail and try again. To look at what is, and wonder, "why"? To look at what isn't, and wonder, "why not"? To see injustice and express outrage. To see intransigence and show impatience. To see possibility and offer excitement. To see the world as it is and know that you can do better.

So for several months we worked on a plan for a youth centre that was in the spirit of youth, for youth and by youth. The World Youth Centre became the Toronto bid's "Moscow Surprise," announced the day before the IOC vote.

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It didn't work, of course, but we realized by this time that the idea had merit, Olympics or not, whether it existed in a single physical space or not. Its value was as a way of thinking about youth, of developing youth; of thinking about and trying to remake the future. The concept wasn't easy to explain to others. Put in a few words, it sounds too abstract. After several failed attempts, I finally tried this way: "Do you believe that today's adult represents the ultimate stage of human development, of human achievement; of human possibility?" Of course not, they said. "Then why do we encourage youth to be mini-adults? Why don't we use the time of youth differently? To encourage youth to be youth. To learn and grow in different ways. To grow up to become different adults. To redefine youth. To redefine adulthood. To create a different world." Then they understood.

What they understood is what I understood one day last spring when I was given a page of phrases to read by some of the kids who worked on the Toronto bid. They call them "'zines," a piece of paper folded to create several little pages with just one word on each side – like little magazines – the words together forming a phrase:

> Let's listen carefully and see how we change.
> Let's be messy and see what we find.
> Let's think with our minds.

As you can see, the wonderings and musings of these kids, their way of putting things, is different from an adult's. They shift understandings just a few degrees, to where the world looks a little different, to where we can begin to imagine a world that functions very differently:

> Let's make up new words.
> Let's spend more time.
> Let's take field trips and see the world.
> Let's play freely here.
> Let's start right now.

Imagining a different future

I think we have some hard thinking to do. This may be a time now to get through the worst of these tragic events in the only ways we know how. But very soon, in the light of what September 11th has made clear, we need to begin to imagine a different future.

In the world, once there was division. Different peoples lived in different places, unknown to each other. Living in different circumstances, they lived in different ways; they spoke

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different languages. Then we learned to move from place to place, and discovered each other. No longer protected by distance, we learned to put up barriers – fences, walls, national boundaries. Then, technology breached those barriers. Once, there had been no possibility of understanding; but with division, there was protection. Now, without division, our only protection is in understanding.

And understanding has never been more possible. Today, we can travel and walk in each other's footsteps, talk each other's languages, learn each other's ways. With new technologies, we can avoid official gatekeepers and connect anywhere, any time, person to person. We can if we want to, and youth want to. It's natural to them. Youth look at war with impatience and outrage, and cannot imagine why. Adults shrug – it's human nature. But is this understanding of human nature really only that of adult nature? Is youth nature different? We talk about youth's willingness to risk, take chances, to fail and try again. We talk more and more about the need for adults to do the same in business and government, in order to compete, to succeed. If youth nature is different, can it remain different? Does it have to grow old, or is something else possible? That's what we need to find out. The freedom and fullness of our future lives may depend on its possibility. As adults, that's what we need to encourage and allow.

A national Youth Commissioner that offers an annual story of the state of youth, a youth centre where the reach of human possibility is tested and explored – that's how we can pull our communities together to serve young children and begin to help our kids do better. I used to be more patient about the need to take steps like these. I used to think that tomorrow we'd know a little more, so tomorrow was okay. I don't think that way now. We know enough. Our existing path to the future will not work. It's time to act. We may fail if we do. We *will* fail if we don't. It's time to begin the real learning.

Ken Dryden is the President of the Toronto Maple Leafs. He is the winner of six Stanley Cups, author of four best-selling books, and was recently honoured, with his wife, by the Canadian Institute for Child Health with the 2001 National Child Day Award for exceptional work with children and youth

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KEYNOTE

Enabling Conditions for Healthy Child Development

What Does the Research Tell Us?

by Judith Maxwell

I am delighted to join in sharing new developments in research on children and youth. I want to use the opportunity to talk about the challenges of knowledge transfer. Although CPRN is regarded as a knowledge broker, there is no simple direct route from research to policy to practice. In fact, it is a messy, chaotic route. The way forward is not clear, but I have some suggestions to put on the table.

A societal challenge

- Healthy child development is a family responsibility. But families are nested in communities, workplaces and society. So, child development is a societal challenge.
- Research using the National Longitudinal Study for Children and Youth (NLSCY) has highlighted the importance of parenting and community effects.
- The key challenge for researchers is to show society how and why to invest.

Enabling conditions for healthy child development

Healthy child development depends on:

- Adequate income
- Effective parenting
- Supportive communities

The first condition, income, has been a focus for policy but we haven't fixed the problem. Governments are highly conflicted about their role when it comes to parenting and communities. At heart, this is a question of values. What research can do is provide the linking logic to inform societal choices.

Messy relationship between research and policy

The route from research to policy implementation is chaotic and unpredictable. Research is mostly linear logic, while policy making is non-linear – action and reaction among many policy actors. Two key actors are governments and employers. And neither one would naturally choose early childhood development as their first priority. Let's look at a few recent examples.

The National Child Benefit – a policy success

The National Child Benefit (NCB) was a breakthrough, a multilateral success with incremental gains. In July 1998, both federal and provincial governments began to implement the NCB. This was the first new social investment in many years. It provides a mix of income and services for most families, but is more generous for poor families. Ottawa invested in a refundable tax credit. The provinces reinvested savings in services and supports for children – based on their own preferences/needs. The program has been enriched several times, but is still far from complete.

Parental leave – another success

Ottawa extended paid parental leave under Employment Insurance (EI) from six months to one year. This supported parenting and family income and created choices for parents. As well, it encouraged fathers to share in early development of their children. This was a unilateral federal decision, but within a year, all the provinces followed through with changes in their employment standards for paid parental leave. Nonetheless, their remain gaps in access to these EI benefits.

Child care – a disappointment

No significant investments were made in child care in most provinces in the 1990s. One very large exception is Quebec. Elsewhere, early childhood programming is still patchy and highly targeted to specific disorders. Autism and FAS/FAE, for example, are serious problems for some but focusing on these alone leaves other children and families stranded. Many other child development issues are ignored. Child poverty continues to be a serious problem. So much policy work remains to be done in this area.

The progress in child care from 1998 to 2000 narrowed but didn't close the gap between needs and the contribution of society. The knowledge base has become even more convincing thanks to the efforts of many, yet, the policy momentum seems to have stalled.

I believe this stall is for two reasons: basic value conflicts in society; and the chaotic and unpredictable relationship between knowledge and policy.

Value conflicts

Beauvais and Jenson map two paradigms: family responsibility and investing in children. Each of these has its strengths and weaknesses, and each one is incomplete on its own. Family responsibility has governed policy for many decades. But parents options have narrowed. And society has an interest in supporting the development of *all* children. Investing in children ignores adult needs and is not sensitive to low-income need. Ideally, we should blend the best of both models to do the best we can for children.

Challenges to knowledge transfer

a) Timing: Research takes a long time to gestate; policy analysts have no time to go back and review the literature; they want results now.
b) Uncertainty: Academics don't like to call closure on an issue, the truth is always contestable. Policy analysts are looking for certainty, preferably a synthesis.
c) Cultures: Researchers don't know what kind of information is useful at different stages of the policy cycle; when values are in conflict, policy analysts need to know what works.

Key enablers for transfer

a) The political will to learn and engage: With this, Ministers and Deputy Ministers create the demand for knowledge and good policy work.

b) Windows of opportunity: Moments in time when the constellation of political and economic forces create possibilities for shifts in policy direction.

For example, in the case of the NCB, the window had to open simultaneously in many jurisdictions. Yet the window that opened in 1997 now appears to be closing. Why? When the window opened:

- child care initiatives in the 1980s had died due to lack of money and lack of consensus;
- seeds of the NCB idea were sown in the Social Security Review in 1993;
- sustained and effective advocacy work about child poverty kept the pressure on;
- there was leadership from B.C. and Quebec where momentum was building for a new approach;
- a trust relationship between federal minister and colleagues – a moment in time.

And so on.

Barriers to policy progress

a) Fiscal realities: Deficits and debt were the key drivers of policy through the 1990s. Between 1999 and 2001, there was a brief surplus period. Now, economic slowdown has created a "chill."

b) Political considerations: Values conflicts on the responsibility of families and state still block progress in some jurisdictions. The turnover of ministers and officials in 1999 impaired collaboration on and commitment to the children's file.

c) Jurisdictional issues: Federal-provincial/territorial relationships soured, despite the successful negotiation of the Social Union Framework Agreement. There were new governments, with unilateral agendas such as over health care.

Possible opportunities

The landscape has shifted on many fronts. Where and when will new windows of opportunity occur? And how can the research community make a difference? I would not predict new large scale, multi-jurisdictional initiatives, but there will be smaller scale opportunities. We can lever new themes, new institutions and new governance models.

a) An emerging theme: Work-life conflict is becoming an epidemic. Stress on women and men has risen sharply over the past decade and is becoming a "societal" issue. We need to have early documentation of these impacts on health care costs, industrial costs (absenteeism, turnover), how it impacts all income groups, how it impacts parents and non-parents. This may be the platform we need to bring employers and governments back into action on a range of issues that also affect children.

b) New institutions: Regional health authorities are confronted by the spillovers from health to social care. We require a new decision-making authority with the power to think and act horizontally, knowing that spending on social care relieves pressure on health budgets. A few new forms of institution are beginning to deal with families and children in a holistic fashion. If health reforms begin to integrate primary and acute care, this trend would be reinforced. The climate is growing for a prevention model to prosper.

c) New governance models: As accountability becomes fashionable, there will be resources for careful evaluation and tracking. Decision-makers want to know what works. For example, the Self-Sufficiency Project results provided a treasure trove of evidence on welfare-work. Results like this can mobilize non-state players – such as employers and advocates – to demand more effective public policy. And governments can work with employers and voluntary organizations to achieve shared goals.

The way ahead

Researchers have to carry on with steady progress on knowledge creation, but should not miss the opportunities to:

- recycle what you have learned for a new minister (since they change often);
- link results to new and emerging agendas;
- hammer away at defining "what works";
- nurture social advocates who can help create the windows;
- create the linking logics that break through the values conflict.

Researchers can't do it alone. But policy makers can't do it without them.

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KEYNOTE

Society and Developmental Health

by Daniel P. Keating

There is a broad and growing recognition that early child development is crucial for the health, well-being, competence and coping of individuals, populations and societies. This understanding is increasingly supported by substantial, specific evidence from a range of disciplines including the neurosciences, the developmental sciences, epidemiology, economics and others. Despite this recognition and the strong evidence to support it, Canada does not yet have a coherent, integrated system for supporting optimal development during early childhood.

Although Canada is not alone in this regard, it is imperative to move toward establishing an effective and systematic approach to early child development, given the range and magnitude of potential consequences if we fail to do so. Among these consequences are significant risks to population health, competence and adaptability, and the associated difficulties of maintaining a well-functioning society and an innovative, productive economy. On the other hand, investments in early child development that are systematic, sustained and based on the best available scientific understanding of the core dynamics of development are likely to have dramatic positive impacts on both economic and social advancement.

The Scientific and Social Context for Early Child Development and Education

To begin, I want to emphasize one key point by making a somewhat controversial comparison. Strategic investments in early child development will be successful only if they are "based on the best available scientific understanding of the core dynamics of development." Even though there are numerous problems associated with the promotion of health and with health care in the population, it is nonetheless clear to all that there *is* a health care system.

Furthermore, this system is firmly rooted in the medical and biological sciences, from public health to molecular genetics. Specific controversies about treatment or prevention models are understood, so far as the public agenda and public policy are concerned, to be argued and resolved within a scientific framework. The point is that we are unlikely to succeed in the crucial project of providing optimal supports for developmental health in early childhood unless we root it firmly and unwaveringly in the scientific model, where cumulative knowledge-building leads to better and deeper understanding and practice.

Let me be clear that this is not to dismiss the wisdom of approaches rooted in the humanities; indeed, that is often a key resource for looking more closely at issues that the narrowly analytic scientific method can overlook. Rather, it is to take ideas from all sources, and to subject those ideas to rigorous scrutiny. The strain of post-modernism captured by the cliché "anything goes" is not a good mantra for either health or development. What does the best available scientific evidence tell us about the nature and importance of early child development?

The Scientific Evidence for the Importance of Early Child Development

To draw this scientific portrait, I briefly review the key arguments and evidence that we assembled in the *Developmental Health and the Wealth of Nations* (Keating & Hertzman, 1999). Although each point below summarizes a large body of evidence, the overall picture can be drawn in a series of connected observations.

In all societies, there is a significant association between social and economic status (SES) and health, but societies with sharper differences across this SES gradient have poorer health outcomes overall compared with societies with flatter gradients. This inequality of health outcomes as related to social indicators (of wealth, income, education, and occupational status) has been documented universally, including the most economically advanced countries.

Where this work has been extended to other developmental outcomes, such as literacy, mathematics achievement, behavioural and emotional problems, the same pattern emerges. Thus, for the full range of outcomes from physical and mental health to competence and coping, which can be combined into an omnibus indicator that we have termed "developmental health," there emerges a similar portrait: *Societies with sharper social status differences have generally lower developmental health.*

When these epidemiological patterns are explored longitudinally, this same gradient effect is observed using social status indicators of the individual's family of origin. This suggests that whatever the gradient effect is, it operates across the life course, from early childhood to outcomes of developmental health much later in life.

Although further research is needed to more firmly establish and refine this picture, merely confirming the gradient effect for developmental health is not sufficient either for our scientific understanding or as a guide to social and public policy. We need to "unpack" the gradient effect in order to understand its fundamental processes and mechanisms.

Clues can be found in the specifics of the gradient effect itself. It is pervasive, showing effects across many outcomes of developmental health. It is portable, in that individuals apparently carry this legacy with them into new contexts and circumstances. And it is enduring, in that it is observed across the life course.

These clues point toward a working hypothesis of "biological embedding" in which the contexts and experiences of early development are registered in the biology of the individual, and expressed in various ways across the life course. Exactly how these "embedded" processes will be expressed is also contingent upon contexts and experiences of later life.

Recent research in the neurosciences is consistent with a notion of biological embedding. The neural system includes the central and peripheral nervous system, including higher level processes of cognition and executive function. The neuroendocrine system is largely responsible for the production and circulation of neurochemicals that have many functions, including patterns of emotional responding. The neuroimmune system governs the way in which the body's natural defences respond to physical challenges from invading bacteria or viruses, or from physical trauma.

In all three systems (which are interactive and developmentally interdependent), there is evidence that experiences during early development shape their structure and/or function in enduring ways. These influences begin even prenatally, such that the mother's exposure to significant stress during pregnancy is linked to lowered levels of immune response in the infant, and this effect is observed well into maturity.

It is important to draw a distinction between the notion of biological embedding and the often, and justly, criticized notion of "infant determinism." The latter notion argues that early experience equals destiny. Biological embedding, in contrast, is a working hypothesis

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about the substantial and enduring importance of early development, supported by evidence from the biological sciences, especially neuroscience, and the social sciences, especially longitudinal and comparative epidemiology. Those who argue the opposing extreme position, dismissing the early years as "nothing special," miss the consilience of the evidence (to use E.O. Wilson's phrase in his 1998 book of the same name), across disciplinary boundaries and focus unduly on one particular body of evidence or line of inquiry.

The Societal Implications of the Emerging Understanding of Early Child Development

If the working hypothesis of biological embedding is essentially correct, the implications for society are profound. Not only does it provide a biologically grounded account of crucial patterns in population developmental health, but it also suggests that societal investment – or the lack of investment – in early child development has pervasive and long-lasting downstream effects.

Recent work in economics points to the strong likelihood that the growth economies of the 21st Century will be the knowledge economies, in which innovation is the key ingredient. This, of course, is fundamentally a human resource, and societies that do not sufficiently attend to the conditions that generate that resource run the risk of lacking the key ingredient of the future growth economies.

Recent work on social institutions suggests further that it is not only the availability of human resources that matter to well-functioning societies and economies, but also how those resources are organized. "Knowledge" societies are characterized by higher rates of participation and engagement, and by greater reservoirs of social capital. The levels of competence and coping in the population are thus also resilient "learning societies," which points our attention again to the central importance of early child development.

Both these points are becoming increasingly recognized in international forums, as in the presentation by economist Jacques van der Gaag to the World Bank Conference last year (*Investing in Our Children's Future*, Washington DC, April, 2001).

Thus, it is essential that we understand in detail the link between the scientific knowledge about early child development and a societal agenda that can translate that knowledge into useable programs, policies and directions for community and social organization – to move toward a learning society model for early child development. For both purposes, a network model is the only one that can work, given the interdisciplinary nature of scientific inquiry and the urgency of moving that knowledge into social action as rapidly as possible.

As we undertake this task, it will become critically important to understand the dynamics of change that are now upon us. We have characterized the nature of this change as an innovation dynamic, in which an accelerating feedback loop has been created through the interaction of our evolutionary and cultural legacies in human development. The acceleration is evident from the timing of the major changes in how Homo sapiens has lived, once having acquired a penchant for reproducing culture, from the Neolithic Revolution of 40,000 or so years ago, to the Agricultural Revolution of some 10,000 years ago, to the Industrial Revolution of a few hundred years ago, to the current onset of the Knowledge Revolution.

Although historically we often focus on the technological breakthroughs characterizing these sea changes in human experience, it is clear that they are equally provoked by social innovations (respectively, cross-group communication, urban concentrations for knowledge generation, and globalization of trade and information), and in turn provoke the need for new social arrangements. Even a cursory review of contemporary demographics and labour markets indicate the degree and pace of change that we now experience – as if our own lives were not sufficient evidence!

What may make this current "revolution" different is the potential to use the essence of the innovation dynamic in a conscious way to support broader human development goals. If we use the information we now have, and that we will develop, about the core dynamics of human development – especially early child development – to design flexible systems to support development, we will move toward what we have characterized as a "learning society," capable of monitoring and adjusting social practices and institutions toward that goal. In the same way that we routinely use economic and environmental feedback loops to guide policy, we clearly need "human development" feedback loops that now exist only in rudimentary form.

As we do this, it will raise the issue of "who is responsible for what." The simple answer is that we are all responsible. But that does not go very far in helping to design a system. The role of the various sectors in this task requires close examination, and the designs of integrated systems will need to be judged by whether they get the job done. Especially worrisome right now are the tendencies to offload responsibilities to communities without the support of senior governments, or to assume that universal programs will replace the need for specialized services. Only when we view the enterprise as a system, and monitor how that system is functioning, can we move this agenda forward. The reality is that we already have the major tools to do this. The challenge is to use those tools thoughtfully.

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KEYNOTE

Sacred Lives

by Cherry Kingsley

When I do any kind of public speaking, I talk a lot about my experiences in the sex trade and prior to the sex trade just to give people a sense of my systemic experiences and how somebody gets into those circumstances. I will tell you a bit about that today, but I want to talk more about how I got out of the sex trade, and about the factors that changed my life and propelled me from victim to a different place in community and in society.

I grew up in a home where there was a lot of violence and abuse and alcoholism and neglect and fighting and yelling and all of that. I remember telling a teacher about the abuse that was happening at home. I was pretty young. It was actually just before the International Year of the Child and the class was talking about this notion of children's rights. Because the teacher had talked of all these different things, I wanted talk to her about what was happening to me.

She phoned my mom. Then, when I got home I was beaten. This really taught me that I couldn't talk about these things and that if you told, then you got into trouble and that people don't really want to hear it anyway.

Other times, police came to our home and would say when my parents were fighting and drinking and stuff, you know, "Quiet down. You are disturbing the neighbourhood." Even though they saw me and my sister there, they didn't really say anything to us. They didn't ask us if we were okay or anything.

So I grew up really feeling that these are things that you can't talk about; that you don't talk about; that if you do, you get in trouble; and that really nobody wants to talk with you about them anyway. I grew up embarrassed and ashamed about it and holding it inside. After I told that teacher, I never asked anybody again for help for a very, very long time.

When I was 12, in Calgary, I skipped school. I went downtown with another girl and we hung out in a park. An older couple was there and we became friends. They never promised me things. They would take me out for coffee or to a movie. When I didn't want to go home, they let me stay at their place.

When I was 14, this couple was going to Vancouver. I didn't want them to leave because they were actually the only friends I had, the only people that I felt understood me and didn't bug me about everything or make fun of me. They told me I could go with them, that they would take care of me and put me in school. I thought I could just leave everything behind, start new. Not have to be an abused kid or a welfare kid any more.

So I went to Vancouver with them. It was Halloween. I had never seen the ocean before. We got a hotel room and then the guy said, "Well, you have to go and work. We have only money enough for one night at the hotel so you have to go to work."

I didn't know what he meant, despite the images on TV. Working meant 18 hours a day or more; 8 to 10 clients a day or more; beatings all the time, not just from him but from some of the clients; being harassed by police and people driving by throwing things and calling me and the other people that worked names. Basically, it was slavery. I wouldn't even have money in my pocket for a coffee because they took all the money.

Eight years I was in the sex trade, off and on. I don't think I ever wanted to be there. I think I was just waiting for an opportúnity to get out. But by the time I was 15, I was a heroine and cocaine addict and that was part of what kept me there. But a big part of what kept me there was that there was nothing else, I was so alienated. Years went by without having conversations with people outside of the sex trade. I didn't know other people. It was a pretty isolating and alienating experience. Not a lifestyle though, but experience.

The first thing that started to make a difference in my life and helped me get out of the sex trade was being able to talk about my experiences. When I first got out, I could never have come to a conference and talked about this. But I did talk about it with friends and peers and people that had a common experience.

Franky, a friend who died, and I used to write a newsletter together – stories and poetry and things like that. Anything to try to give voice: to talk about the things that were happening in our lives; the issues and things we wished for, things we wished were different and things we wanted to achieve.

That enabled me to start really giving voice to what was going on in my life and in the lives of my friends. But I still would never have talked about it publicly, except that most of my friends were dead or dying. That is when I finally started to feel compelled to talk out. They were dying from AIDS, from drugs, from suicide and some were murdered.

I knew we had to talk about it because we weren't surviving out there. People needed to know that. People also needed to know that we were not adults out there making conscious choices and empowered by our decisions; we were young children and youth that were dying and being abused and enslaved in North America – not some faraway country. That is when I started to feel compelled to talk about my issues and my experiences and to represent other people that I knew.

Mentorship played a huge role in my life then. There were a few people who mentored me, teaching me things like putting together a newsletter, using a photocopying machine, and organizing meetings and small projects. They helped me understand say, the difference between legislation and regulations and policy. I could never have commented on any of those things unless somebody had sat me down and told me what it all meant. I didn't even know what some of the words meant, or the meaning of the jargon that is used so often.

And then I began to be able to have more meaningful input and impact than just coming and telling my story somewhere. I wanted to tell my story so it made a difference; so that people would understand; so it could be different some day. Mentors gave me the tools so that I could make those differences.

I tease Sandra Griffin and I tease Senator Pearson about Jiminy Cricket, Pinnochio's conscience. They put Jiminy Crickets on me that hound me.

Senator Pearson taught me that with opportunity comes obligation. I really believe that. As I get more opportunity, I am truly obligated then to try to be truthful and honest and at times, even if you are nervous, courageous. And because I have that chance and because so many people that I know don't and may never have that chance, there is an obligation that comes with that opportunity.

One of the things that Sandra Griffin taught me happened one day when I was really tired and hungry because I hadn't eaten yet that day. I was supposed to close a five-day conference that I had been involved in organizing and I just didn't feel like it. I felt emotionally drained because it had been very intense.

I was sitting in the bathroom crying and telling Sandra, "I am tired and hungry and I don't want to do this any more." And she said, "Yeah, I know you are tired and hungry and all that and sometimes it is not about you."

I thought about that. She was not saying that you ignore your needs or that you be a martyr. Sometimes there is the chance you are given, and even though it is given to you, it is not about you. There are times when you truly have to represent even if you are tired, even if you don't feel like it, even if it is 4:30 on a Friday afternoon when you are planning a long weekend somewhere and somebody walks in and says, "I don't have a place to stay tonight." Sometimes it is not about you.

I have carried that everywhere and tried to understand what it means. It doesn't mean that you treat yourself badly. It just means the opportunities that you have been given can become opportunities for other people if you can you share that and make those links. It is not just about me telling my story; it is about me saying it so that it has a broader impact and that it creates a kind of change in people's perceptions. So mentorship – tormentorship! – has made a difference in my life.

I am First Nations and I never really knew what that meant. One time an elder came up to me and said, "Our life is sacred. Your life is sacred." Nobody had ever told me that before, not my parents, not the 20 homes I lived in, certainly not the pimps or clients I had when I was in the sex trade. It made me interested in my culture.

My friend Franky made me interested in my culture too. Sometimes things seemed so bad, yet somehow he still had faith. He showed me that faith is when everything around you is very, very bad, but you still believe in good. Even though you can't see it, you believe in it. He taught me that through culture, you can have a strong faith in life and in the sacredness of life even though you may not be living it at that moment. That was really what got me interested in my culture and in the Medicine Wheel with all its parts.

On the physical part of the Wheel, when I left the sex trade I was 96 lbs.; I had had three heart attacks from cocaine; I didn't have my own I.D.; I didn't have a bank account; had never grocery shopped, never cooked, never had my own place; I had never had accounts with a telephone company or power company. Physically, I had to learn to take care of myself. I had to eat. I had to try to create a space where I wasn't being hurt all the time. There was so much work that I had to do.

Mentally, trying to think differently; trying to believe in different things; trying to see that it could be different; see that going from a self-concept of victim and passive recipient of services and into this other place of participant. My experiences have been very painful and I will probably live with the effects for the rest of my life. I am sure they affect me in ways I don't even know about. But to begin, I learned to think about it differently and to live with it differently.

On the emotional part of the Medicine Wheel, I was trying to heal; trying to not live in such pain; and trying to channel some of the anger and the pain and make it into a positive change, and letting go some of that anger and resentment and not carry that with me. Again, I will probably work on the emotional part for my whole life but the wheel really helped me to focus.

The spiritual part of the wheel was a sense of faith that I was telling you about earlier.

The Medicine Wheel became my map because I felt so lost. I was so lost and so far in the dark that I needed a map to find my way out. The Medicine Wheel was that for me.

My culture also gave me a sense of faith and a sense of vision beyond basic things. When I was younger, I used to talk about food and housing and AIDS prevention and suicide prevention and the violence that is perpetrated against children, all of that.

These are all still very important to me, but my culture gave me a broader sense of vision –- one of peace and of justice. It doesn't just have to be about protecting ourselves from horrible things; but what are we aiming for at the end of the day? Is it just *my own* life free of violence or is it *life* free of violence? My culture helped teach me a different kind of vision.

The other thing that changed my life was being put into a leadership role. People believed in me and people saw me, not just as a passive recipient of a service or a victim or somebody's issue or mandate or project or income, but saw that there was worth in me, that there were qualities and a strength in me; that my story or my voice was important. They gave me opportunities to have that voice; to have it even if it conflicted with what they were saying. They invited me and made me feel welcome. They supported me and gave me resources to be there.

Being a leader has shown other young people that have lived some of the same circumstances or are living them now, that they too can be leaders; that it can be different and that they do have a role and, at times, a responsibility to look out for some of the littler ones, to take care of each other, to make it different some day, not just for themselves, but make it different period. A lot of young people over time, seeing my leadership, have become leaders, which is pretty exciting to see.

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What are the things that I treasure most in life – aside from my son, my little bear? First, my freedom. Freedom to me is something very real and alive and important. Not just freedom from violence and abuse and exploitation and drugs and poverty and homelessness, but freedom to be the things that I believe I can be. Second, I treasure my voice. To be able to have a voice, to say things, to challenge, to question, to agree, to think up my own ideas that are maybe very different and to share that with people.

Those are the two things that I treasure most. Sometimes people take those things for granted. I think we should cherish those things, particularly at this time in our world, the freedom and the voices that we have.

When Landon Pearson said "Leave no child behind," it resonated in me. It is so important that we don't leave certain children behind. Sometimes I listen to people speak about why they love children, about why children seem so precious to them, it seems they tend to focus on things like "sweet" or "cute" or "innocent" or "pure." Those things are true for sure, but that may not be the most important reason we should value and love them, recognizing even little babies as human beings with rights.

We don't have to be grateful to you. We don't. Sometimes people expect me to be grateful that I am not in the sex trade any more. But I never should have been there anyway! Why do I have to be grateful for that? Why should I be grateful to eat as a child or be grateful to have a place to live?

This notion that children owe gratitude for such basic things when they can't control those things; they don't have the power in our society to distribute resources and allocate funds and build housing and share the wealth more evenly. If children had a say in some of those things, you can bet there wouldn't be so much violence or exploitation or abuse.

We have to engage some of the most marginalized populations, not just because it is the nice thing to do or because we feel sorry for them, but because it is their right. They have the right to basic things like food, shelter, and freedom from violence. But they also have the same rights as other children that maybe aren't faced with their circumstances.

It is not about helping poor pathetic little children. Sometimes circumstances can seem so big and opportunities so small. Fear can really change a child's perception of what their choices are. So if there are things in their life that make them feel afraid, then what they perceive as their choices becomes more and more limited. We have to make sure that opportunities exist and are visible to all children.

It is also about not viewing children and youth solely as an issue or a victim or whatever might be going on for them. To engage children and youth is important because it is not just

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the responsibility of adults or professionals to make this world okay; children and youth also share this responsibility. By engaging them, they are given opportunity and they are given the support and the invitation and the resources that they need to make this world okay.

We don't have to earn our right to be in a circle, like the community or the family. We are born there. We don't have to earn our right to be there. We don't have to be good and then we get to be there. We are born there, and that is not a passive rule; it is an active rule. So every chance we get to be engaged, then we learn that we are part of the circle.

No matter how marginalized children are, there are leaders amongst them. They don't have to be a recipient in a food line or a social housing line or a resident at a shelter. All those young people are potential leaders. They maybe not be typical leaders at a podium with a microphone, but even on the street, you see young people play music in doorways or write in journals; they all have some kind of gift, some way in which they can share their voice. It is about making opportunities more available to them.

This morning when Dan Keating was talking about hyppocampal neurogenesis, what I got from him was that, although we are born with a set of tools that we will have for life, and you may not be able to change all of that because you are born with it and circumstances sometimes dictate it, yet there are always opportunities for new cells and new growth.

What I thought of when he was talking about linking research and policy and practice I thought about how those links could be hyppocampal neurogenesis for young people. When I overdosed and was in the hospital, that could have been a hyppocampal neurogenesis moment if someone had asked me: "Okay, do you want your life to be different or do you need help?" Even if it seems like a crisis right then, there could be an opportunity.

So how do we get research and policy and practice to be those sparks of opportunity and growth for young people and always try to think of it that way?

I would also like to add experience to research, policy and practice.Some people may not come to the table with a research paper or policy experience or even practical experience, but they come to the table with life experience. That should be included. That should count for something. It is not just come and tell your sad story but also to give your perspective on how we might address some of the issues.

I think experience is important because then it means that as policies and research and how they are practised get developed, for an issue like homelessness, for example, it would make sense that you talk to people who are homeless. It makes sense that if you want to create policies for women and do studies on women, they would include women.

It is the same concept for children and youth. They may not be able to share their voice at a traditional workshop or conference. It is not up to them to fit into our framework; it is up to us to create a framework that includes all of them.

It is really important that we leave no child behind because if they are not at the table when we are talking about homelessness or poverty or addiction or suicide or exploitation or child abuse, then it is never really going to be linked to them. I think that what we are trying to achieve is lasting, meaningful impact.

Sometimes, I think we also have to be willing to go vastly outside of the research and knowledge and policy frameworks we have accumulated when we are presented with somebody's experience that doesn't quite fit into what we know. You don't have to throw everything out, but just be willing to expand on it so that you can include those young people and their experiences and their needs.

When I was at the UN Special Session Preparatory Committee in New York, I sat and listened as nations debated the death penalty for children, the use of children as soldiers, children as targets in war, sexual exploitation of children, and whether or not we should continue to criminalize and jail them. It made me so sad. In those situations that are so vastly, hugely out of whack with what children are living daily, you just wish that for once, delegations of children could be debating some of those issues because the outcomes are so vastly different. These are the same children and young people who will one day be practising or applying those policies and vision, if you want to call it that.

But then I came home to Canada and, in a taxi, I listened on public radio as people debated the validity of spanking and hitting children. It wasn't even a debate about *whether* you should hit children, it was about *how* you should hit them; whether it should be with sticks or belts or spoons, bare hands; whether they should be clothed or bare skinned when you hit them, that kind of debate.

I remember one man phoned in and said, "Well, you can't use logic with them when they are young. You can't reason with them. They are like dogs at that age. They aren't going to listen to you if you try to talk with them." And I wanted to ask him, "At what age do they become human? At what age are they human beings with human rights?"

With any other segment of the population, it would be a hate crime if you sat and talked about hitting people. Put women in that debate and whether or not you should hit women with sticks or with belts or with spoons and on bare skin. Or put native people. It is offensive. It is shocking. It incites violence against a segment of the population that have no power, no vote, and they are little. If we are going to make change in this world, it is not always just about changing young people. It is about changing some of our own practices and policies and research.

Children and youth should always be able to recognize themselves in research, policy and practice. They should be able to say, "Yeah, I get what you are saying. That makes sense. I can relate." It should be that way. It shouldn't be vast, impassable canyons between young people and their needs and their issues, and how we talk about young people and their needs and their issues. It should be dialogue that is very easily understood and two way, reciprocal.

We should be working on all of these things and working with young people in all of those ways because it is their right. Their human right. And it is children's right. We need to set our standards higher than just basic needs so that we leave no child behind.

We should be doing this because peace in this world is intrinsically connected to justice. There can be no peace without justice. There can be no justice when children aren't fed or are beaten or are bought and sold in our country. If we ever hope to have a nation that is just and peaceful, it will be because we have raised our children in that way.

Cherry Kingsley is the winner of the Governor General's Persons Award (2000) in recognition of her work with young people who have been sexually exploited. She is author of ***Finding Our Way*** *and co-author of* ***Sacred Lives: Canadian Aboriginal Children and Youth Speak Out about Sexual Exploitation***.

PANEL PRESENTATION

Introduction to The Five Centres of Excellence for Children's Well-Being

by Jenna Hall

Your sponsors for the conference today had the foresight to think that it would be interesting for you to be able to spend a little bit of time getting a view of what the program is all about and what the five Centres of Excellence for Children's Well-Being are doing and what their vision is for the five-year mandate.

The Centres are an experiment on how the government can do things differently than it has in the past. It's an experiment in partnership, in cooperation and in decentralization, and it's an experiment that has the potential to permanently change the landscape of child development and of public administration in Canada.

The Centres of Excellence approach is to make the best use of the skills that are out there in the community by promoting collaboration across sectors and across disciplines, developing national networks, and creating strong and enduring partnerships. They are based on excellence and research with a view to translating the information into sound policy, which then provides the basis for effective programs.

The Centres' program challenges old paradigms in a number of ways: by moving away from a traditional model of research and pronouncement; by ensuring that research is relevant to the needs of those of you who work in the field, and by being anticipatory instead of reactive. Each Centre strives to complement the efforts that are under way at the NGO and community-based groups and to facilitate national dialogue by citizens that participate in these programs.

This allows them to identify and take advantages of linkages among initiatives, fill in identified knowledge gaps and anticipate the issues of tomorrow. In doing so, we can develop a comprehensive program that includes meaningful research and dissemination of relevant information to those who need it the most, and improve capacity to use this information to obtain results through policies and programs.

This approach has resulted in five Centres of Excellence for Children's Well-Being that are becoming nationally recognized sources of expertise and knowledge. It also translates into more informed collective decision-making for child and youth health-related policies and programs.

The program is off to a strong beginning, but the time frame before us is limited. We are now entering the second year of a five-year program and we have ambitious objectives to achieve. We want to demonstrate the success of a new public management approach to designing and implementing programs for children, an approach that we hope will fundamentally change the field and become a proven concept for future federal investments.

We want to create sustainable, multidisciplinary policy communities that take advantage of new technologies. We also want to foresee and intercept critical trends in child and youth development. All of these objectives converge in improved health for Canadian children and youth.

I hope the legacy of this program will be that experts from all walks of life will be compelled to work together to advance what we know about healthy development and to use knowledge about children for children.

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PANEL PRESENTATION

Centre of Excellence for Early Childhood Development

by Richard Tremblay

Why do we need a Centre for early childhood development? Like the leaning tower of Pisa, we have a problem at our base. To make sure that Canadian children do not grow looking like the Tower of Pisa, we have to start at the base.

There is a lot of knowledge being disseminated but what knowledge can be considered reliable? What can we call excellent knowledge? How do we define excellence? At the CEECD, we have decided to focus on knowledge based on empirical research of the highest quality. Knowledge that has been published in the highest quality journals.

Our mandate is to promote the dissemination of scientific knowledge on social and emotional child development, and on policies and services that can have an impact on this development. Our mandate is also to recommend best services to implement in order to ensure optimal childhood development. We want to disseminate this knowledge to service providers, service planners, policy makers, educators of professionals, researchers and the general public.

Our activities include:
- analyzing research on social and emotional child development
- disseminating knowledge
- encouraging and taking part in cutting edge research
- providing assessment tools to service providers
- providing consultation services on policies
- encouraging knowledge sharing

In order to do this, we have created three core committees: the Childhood Development Committee analyzes work done by international experts; the Services Committee analyzes research on current practices; the Policy Committee examines research on Canadian and international policies.

The topics we are currently working on are the following:

- Tobacco during pregnancy
- Stress and parental leave (prenatal and perinatal)
- Low income during pregnancy
- Foetal Alcohol Syndrome
- Reproductive technologies
- Nutrition during pregnancy
- School completion
- School transition (from daycare or home to kindergarten)
- Aggression

The products that you can expect from our Centre are a quarterly newsletter, a website, videos, multimedia CDs. We are also working on an inventory of researchers. At the end of our five years of existence, we will produce an encyclopaedia on the role of early childhood for social and emotional development of early childhood.

Richard Tremblay is Director of the Centre of Excellence for Early Childhood Development. The Centre is located at the University of Montreal, which also funds this Centre.

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PANEL PRESENTATION

Centre of Excellence for Child and Youth-Centred Prairie Communities

by Darren Lezubski

I think most of us are aware of some of the challenges we face, but we also need to turn some of those around and start to look at those as opportunities. Try to use them as a springboard to move the uniqueness that Prairie communities experience to a way of fostering increased centred knowledge. Find out what we can learn from each other and engage each other as we learn.

We have taken a unique approach in terms of how we have decided to proceed. We are using a community development-based approach to doing this and we have a number of networks spread across the three Prairie provinces. They involve a number of researchers really trying to encourage community involvement, academics, getting the people who generally aren't sitting at the same tables, to sit and talk and learn and discuss amongst themselves.

There are four key pillars that serve as a foundation. The first is the Aboriginal community, and particularly the Aboriginal Health and Wellness Centre because everything that underlines the work that we are going to entail is really built on a health promotion framework, and even within that something that Dr. Judith Bartlett has articulated quite often, is the notion of medicine as real life promotion model and that underlies all of the work that we are doing. It respects the importance of the Aboriginal culture within the Prairies, the Government of Manitoba, particularly with the Healthy Child Initiative, the University of Manitoba and the Social Planning Council, which is the lead organization.

We need a vision that is going to guide us over the next four years. It's a matter of moving beyond just the stuff that we collect and conveying it to a wider audience and using that as a means to convey the message of "why"; not just "what" but "why".

This is the mission of the Centre. We are encouraging new ways of learning and knowing. There are so many great things out there that community people can bring to the table, knowledge that hasn't been explored and accepted and the ways the different communities can learn from each other that we are really going to encourage.

We spent a considerable amount of our first year building the networks and linkages among people and encouraging those networks to grow and continue long after the Centre program has come to an end. Within the Prairies, we have six sites or six networks. We have Brandon, Winnipeg, Saskatoon, Regina, Calgary and Edmonton. Community involvement is critical in that it allows us to respect the notion that the best questions to answer are those that communities are asking. This is what makes research relevant.

The first stage is trying to get a handle on the existing knowledge and defining some of the relevant factors, social factors, and how we define community. The second stage will focus on empirically examining some of the relationships between the findings. The final stage, the third stage, is where we take that research into action and make it applicable.

The world has changed, but I also think there are certain values that haven't changed. That means that tolerance and compassion will eventually rule over violence and terror. That's what we have to instill in each child. To me that's "why" we are here.

Darren Luzbuski is the Managing Director of the Centre of Excellence for Child and Youth-Centred Prairie Communities and works on the Social Planning Council of Winnipeg and the Manitoba Métis Federation

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PANEL PRESENTATION

The Centre of Excellence for Child Welfare

by Nico Trocmé

What we are trying to achieve with this particular Centre is to bring together three core partners: l'Institut de recherche sur le développement social des jeunes in Montreal; the Child Welfare League of Canada and; the Bell Canada Child Welfare Research Unit. These three partners come from very different traditions, use different languages and different approaches to both research and policy development. We are trying to come up with a cross-Canada approach that influences and builds on child welfare policy.

We don't know that much about abused and neglected children in this country. In particular, we know very little about what services and interventions are going to be effective with them. Ironically, this is the one population where our services are probably the most intrusive, the most mandatory in nature, and yet we don't really know much about what it is that we are doing and whether what we are doing works or helps. Yet we are faced with the very real challenge of meeting the needs of these children, children who have been left out of a lot of research, left out of society in many ways, but certainly have been left out of a lot of knowledge-building enterprises.

So the challenge for us is to bring together these groups and to build research, policy and practice linkages that will have impact for these children.

We are organized around five major objectives: to foster research on effective programs; to coordinate research to cross-service delivery systems; to forge partnerships for culturally appropriate practices; to focus over the next few years in particular on First Nations services; and to ensure knowledge dissemination; and to promote effective services.

We are meeting those objectives by focusing on five major functions. We are collecting and analysing data from a number of sources. In particular, for the first time in Canada, we have data from across Canada that describes the profile of abuse in neglected children, and a cross-Quebec study looking at the incidence of child abuse and neglect in Quebec.

We are just starting to reach into this very rich data to start understanding some of the key issues for these families and the key issues for service providers, such as exposure to family violence. This is the most rapidly growing form of reported child abuse and neglect in Canada. This is an area where we haven't developed any clear policy guidelines, we haven't developed any clear practice guidelines and we have very little research with respect to effective interventions.

We have some research on the impact, but beyond that we really don't know what to do. We don't know what is going to be helpful, and in particular we are not clear about how we can intervene without further victimizing children and further victimizing their mothers who themselves may be victims of violence. These are very difficult areas to intervene. This is a key area of focus for us.

We are also supporting specific research projects. One of them is work we are doing with the First Nations Child and Family Caring Society of Canada. First Nations children in the incidence study represent about 10 to 15 per cent of children in families who come into contact with the child welfare system. Already, they are over-represented, but by the time we finish working with these families and these children, they represent between 30 and 80 per cent of children in long-term care. So there is something about the relationship between the child welfare system and this population that is not working well. We have more First Nations children in foster care now than we had in residential schools.

We need to find a way to understand what mechanisms lead these kids into long-term foster care arrangements that may not be ideal. So this is a key area of focus.

Another research project is the Adolescent Risk Behaviour Survey. We are looking at the feasibility of collecting data from children in the foster care system, from children who need home-based services. These kids tend to be excluded from a lot of surveys and research because they are generally viewed as being too hard to reach as a population.

This population is under-sampled if not systematically excluded and we are quite concerned that we know very little about some of the protective factors for these children and youth. What are some of the things that allow them, against all odds, to make their way to university, make their way to higher education? So trying to understand how we can involve these kids in research is critical.

We are also analysing some of the service data and research data from the Études d'incidences québécoises. We are studying interventions of the neglected families in the Family Connection Study.

Given the paucity of data, the paucity of research, the little that we know about effective interventions, how do we start moving ahead into policy development and developing best practices? The first step is to bring together the knowledge that we have. There are many bits of research, not always the most coherent pieces. Part of our job is bringing some of that together. For this first year we are focusing on this question: what do we know about the effectiveness of services provided to children in the home to children who have been abused and neglected?

To generate information, the first thing that we worked on was an inventory of the research that has been done across Canada. Our website houses a searchable comprehensive directory of all published Canadian research in the area of child welfare – 800 or 900 studies, for which there are abstracts. It's a first attempt to start to bring some of this material together. We are developing a directory of researchers – academic, government, agency-based and community-based researchers.

Over 150,000 children and families receive services every year through a service delivery system that has been shaped by essentially one story – the story of children who have died at the hands of their parents. That's not the reality for most of those kids. Unfortunately, we don't understand sufficiently what their realities *are* and what effective ways we can protect them. So that's what we are engaged in with the Centre of Excellence for Child Welfare.

Dr. Nico Trocmé is an associate professor at the Faculty of Social Work, University of Toronto, the Director of the Bell Canada Child Welfare Unit and a research affiliate with the Centre for Studies of Children at Risk, McMaster University.

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PANEL PRESENTATION

Centre of Excellence for Youth Engagement

by Stoney McCart

Our core Centre partners tell us that we were in pursuit of good questions for you rather than good answers, good questions on the way to decode youth engagement. So let's start with why a Centre for Youth Engagement? Research shows a significant benefit for youth engaged in activities outside themselves in terms of educational success, career aspirations, enhanced self-esteem and non-destructive personal behaviours.

Benefits for community include that these individuals show lower rates of delinquency and greater participation as adults in civic and political spheres. In the policy arena, yesterday Senator Pearson asked: "Where are the children and youth at this conference?"

It is now expected that we engage youth. Governments and non-profit foundations demand that we practise youth engagement, yet in practice it is difficult. We want a recipe. We get asked at the Centre for a recipe.

We need to connect the individual to the community and explore why the practice is not happening when the research and the policy indicate that it should be.

What is youth engagement? Defining engagement is a process. It's the cause of much productive debate between various components in our Centre. We offer various definitions on our website but those of us who experience it know it. We see little need to define it.

More importantly, the experiences of many of the core partners of our Centre indicate that it is the adults who need to experience youth engagement, not youth. It is adults who should be our focus. Also, there is very little research on the impact of youth engagement. How does the community school or family change for the better or for the worse if it's effectively engaging young people? Much more research needs to be done on the "who" that is imbedded in these questions. We need to know more about who is getting engaged and who isn't, either as youth or as adults.

These are some of the words of youth charged with the task of defining youth engagement:

> *"The first reaction we had in sitting down to define youth engagement was to reject the idea that one could put into words a concept that is so vast and so different for every person experiencing it."*
>
> *"If you want to captivate me, tell me a personal story."*
>
> *"Share with me an experience that changed your life in some way. Let me see your eyes light up when you talk to me. Let me feel your words jump off the page when you write so passionately about this transition in your life. When you have finished giving me a glimpse into this amazing moment of change, show me this stuff that you have just told me about, the getting involved, the doing something that means something and the accomplishing something awesome. Show me that this is something that I can do too."*

Reginald Bibby, who has been chronicling teen trends for decades, says we have been putting the emphasis on individual versus community success. One of the questions this morning was about boys versus girls. I encourage you to look at some of this work for what is happening, particularly to boys, in terms of this individual versus community values.

But this difference between the emphasis on the individual and the community is showing up in the values of our young people. Bibby says:

> *"Results like these suggest that we adults are doing a good job of convincing young people that they are the masters of their own fate. We are doing a less than impressive job, however, of introducing them to the importance of their social environments."*

You can look to the anti-globalization movement and its amazing engagement of young people to understand more because it really is a pro- movement, not an anti- one. Young people are asking for more public spaces, for more emphasis on community, more emphasis on democratic values rather than free market values. So we need to look at where and when engagement occurs.

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A McGill study on student engagement said that it doesn't necessarily take money; it's a cultural shift based upon human and relational qualities that involve young people at the table as partners involved in decision making.

> *"Student engagement is not primarily activity-based; rather it is primarily associated with deep and complex relationships and interrelationships among people, activities and ideas. We need to understand these complex relationships."*

These questions talk to the importance of engaging youth for their health and the health of our society. How active are they in shaping their lives? Are they condemned to be a generation of consumers rather than producers? What impact does the media have on their sense of efficacy? Is the impact of stressing individual values rather than community involvement values resulting in declared shared public values or in declining support for our public institutions? Are we giving young people enough practice in making decisions so that they can make healthy decisions?

Lanny Jeminez speaks:
As a young person involved in planning, programming, and implementing different activities in the centre such as the research process, I feel that I am part of the solution not just the focus of the problem. So that motivates me a lot. I feel I am growing as a person and I am learning not only from the adults who I get to work with but also from young people. They have so much to say.

And working together, it is making my participation meaningful and effective. I enjoy what I am doing. I am going to keep up. I am going to give my best because I know that there are going to be big changes as a result of our participation.

Dan Breault speaks:
We have found that if you give people a safe environment, as much space to do what they can do, and a little bit of support to deliver that process, young people will make the best choices. Often they can come up with better ideas as all the governments, police, and schools combined. We believe that as Christians are experts on religion, the youth are experts on youth. They have better positions to make decisions on their needs and their lives.

There are lots of issues that we have come across as we work with youth and they push back against the constraints of traditional approaches. These are the major aspects of research we have underway, with youth involved at every step of the way.

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Part of the "how" for us is how are youth involved in our Centre? We started with the Roger Hart-Sherry Einstein's letter of engagement. The letter quickly became a continuum with an emphasis on walking our talk, with spaces for youth-only activity, adult-initiated activity with shared decision-making with youth, and youth-initiated activity with shared decisions with adults. The model is involving and evolving.

There are other models that are being identified and developed. Much of the emphasis is on moving away from their respective hierarchies, looking at circles, recognizing that engagement needs to be appropriate to the context and to the relationships. There is no one recipe.

So our vision is: Change the way research is done; make research accessible to youth; change the adults and environments in which young people live to make them more engaging.

Stoney McCart is the visionary and fearless leader of the Centre of Excellence for Youth Engagement at The Student's Commission in Toronto, Ontario.

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PANEL PRESENTATION

Centre of Excellence for Children and Adolescents with Special Needs

by Julia O'Sullivan

On October 5th 2000, the federal government announced that the Centre of Excellence for Children and Adolescents with Special Needs had been awarded to the consortium led by Lakehead University in Thunder Bay and its partners, the Government of Nunavut, Memorial University in Newfoundland, Mount St. Vincent University in Nova Scotia and the University of Northern British Columbia. Our Centre is dedicated to children and adolescents with special needs living in rural and northern Canada.

Why rural and northern? Because children with special needs face extraordinary challenges no matter where they live, but those in small, rural and remote communities face unique challenges simply because of where they live. The challenges presented for children with special needs by geography, distance, cultural and linguistic diversity have not been adequately described or addressed. Our theories are silent, our databanks almost empty, our children with special needs are under-served and their interests under-represented in service models and policies derived from larger metropolitan populations.

Let me give you an example of what this means. Imagine what it's like to be the parent of a 7-year-old boy who is the only child with special needs in your community. Imagine what it's like to watch the years of his life unfold as you wait for services that never come. Imagine what it's like when – desperate for help for your son – you are given a choice. Send your 7-year-old boy thousands of miles away – away from his family, community, culture and language – to live alone among strangers, for months or years on end in order to receive services. Now imagine how, no matter what you choose, you will spend every minute of the rest of your life in mourning for what you have lost. I can't imagine these things but I know this: no parent in this country should ever have to face such a choice.

The mandate of our Centre is to produce knowledge about children and adolescents with special needs in small, rural and remote communities and to put that knowledge into the hands of people who could use it to a make a difference in the lives of these children. The partners in our Centre did not presume to know what knowledge would be most helpful for parents, policy makers and others. So we asked them. We held national consultations from coast-to-coast-to-coast with people in rural and northen communities. We asked them what definition of special needs we should use in our Centre, what special needs we should focus on, and what research we can do that will provide the most useful knowledge for them. Everywhere we went, their similar answers became the framework for and the focus of our work.

Use a definition of special needs that truly incorporates the reality in rural and northern Canada we were advised. Use a definition that cuts across provincial, territorial and federal definitions. Those definitions are the pillars of inequity because they exclude so many of our children. Use a definition that creates a common standard we were advised, then we will have a place to begin.

Thus, we choose for our definition that of UNESCO. In our Centre, the term special needs encompasses all children and adolescents who require additional public and/or private resources beyond those normally required to support healthy development. This includes all those who require additional resources because of exceptional gifts and talents, physical, sensory, cognitive and learning challenges, mental health issues, and problems due to social, cultural, linguistic or family factors.

The people of rural and northern Canada wanted us to focus on those areas of special need that have national significance in their communities. So we established a national task force to address each area of identified. Our task force on early intervention for children with special needs is led by our partners in Nova Scotia. Special needs in nutrition including food access, adequacy and obesity, are addressed by our task force in Newfoundland. Our team in Northwestern Ontario leads our task force on special needs in learning and communication, including hearing, reading and giftedness. Our task force on substance abuse, including fetal alcohol syndrome and solvent abuse is based in Northern British Columbia. Mental health including suicide, depression and alienation is the focus of our task force led by the Government of Nunavut.

When we asked people in small, rural and remote communities what knowledge they needed, they told us to: describe the context for special needs in rural and northern Canada; identify gaps in our knowledge, fundamental gaps like how many children in our

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communities have special needs; report on best practices, programs and delivery models, and point to ways we can make them culturally and linguistically appropriate for the peoples of northern Canada.

They told us to find ways to use current and emerging technology to deliver services for our children. As the technological infrastructure is developed across the north, advise us about what can and should be built in to enhance our communities' capacity in special needs. These are the issues people asked us to investigate so they became our research objectives. When you report back to us, people said, report in straightforward ways and in our languages – the languages of northern Canada. So that is what we do.

The day after we were awarded this Centre of Excellence, the letters started to arrive – and have kept on coming ever since – from all across Canada, from teachers, physicians, academics, governments. Mostly they came from parents – parents of children with special needs living in small, rural and remote communities. The parents write because they see their children in our Centre. The parents believe that the work we are doing offers hope – hope for equity, opportunity and a better life for children with special needs in rural and northern Canada. Hope that, soon, Canada will be a place where parents don't have to make terrible choices, where children and adolescents with special needs can combine the riches of life in rural and northern communities with the very best services this country has to offer.

This then is the Centre of Excellence for Children and Adolescents with Special Needs – Rural and Northern and in the languages of our children I say to every one of you here, miigwech, thank you, merci, na qoo mik.

Julia O'Sullivan, PhD, is National Director of the Centre of Excellence for Children and Adolescents with Special Needs, Lakehead University, Thunder Bay, Ontario.

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Better Beginnings, Better Futures

Building Capacity and Promoting Development

by Ray DeV. Peters

In 1990, the Ontario government launched a project to discover effective ways of supporting the healthy development of young children, and of strengthening family and community life in disadvantaged neighbourhoods. The project, called Better Beginnings, Better Futures, is one of the most comprehensive prevention initiatives ever implemented for young children. It is also one of the most ambitious research projects of its kind in disadvantaged communities in North America.

Research data have been collected and analysed from eight community sites across the province, covering the first five years in which programs were fully operational (1993-94 to 1997-98). The results hold promise for current and future initiatives aimed at improving the health and well-being of some of Ontario's most vulnerable children.

The project sites were funded to provide programs for either children from the prenatal period to age four (five sites), or age four to eight (three sites). The local communities were challenged to meet a combination of goals:

- to improve the development and well-being of young children, particularly by reducing emotional and behavioural problems;
- to strengthen the abilities of parents to respond effectively to the needs of their children;
- to develop the capacity of the local neighbourhood to help itself by involving parents and other residents in the building of a local organization to deliver programs;
- to provide high-quality programs for children and families that respond to the needs of the neighbourhood;
- to establish partnerships with other service organizations and coordinate programs to support young children and families in these neighbourhoods.

Research Designs

The findings and conclusions presented are based on an analysis of the results from two research designs. "Baseline" information on children and families living in the project neighbourhoods was collected in 1992-93 before the Better Beginnings, Better Futures programs were fully underway. The next year, a long-term research group of 1,400 children and their families was recruited at the eight project sites and in three comparison neighbourhoods. Information on this group of children was gathered regularly over a five-year period.

The research produced two "views" of the impact of the project:

- What changes, if any, occurred among families in the eight neighbourhoods since Better Beginnings, Better Futures programs began, compared to the baseline data?
- How did measures collected about children, parents and their community at the project sites compare to those in the neighbourhoods that were not part of the project?

Local Better Beginnings, Better Futures Programs

The neighbourhood sites were given considerable freedom and responsibility to design and develop programs that met the needs of local residents. Government funders did not impose strict program specifications centrally. The sites had to establish a local organization, with meaningful participation by residents, which chose what programs it would deliver, within available resources. The result was considerable variation in programs from site to site. The younger child sites offered an average of 26 different programs, and the older child sites an average of 16 programs.

Locally Developed and Operated Organizations

Each site successfully developed and operated a local organization that delivered a broad range of programs for young children and families, based on locally identified needs. For disadvantaged neighbourhoods, meeting this challenge was a major achievement, involving the building of community leadership, capacity and cohesion.

Children's Emotional Health and Behaviour

A major goal of this project was to reduce emotional and behavioural problems in young children. The negative consequences of allowing emotional and behavioural problems in children to escalate through the school years is well known. Sites that showed the strongest improvements had programs for children that were focused, intensive and continuous.

- Where programs for children 0-4 were sustained from infancy (home visiting) through the preschool period, with parent-child playgroups and quality child care, children started school with less anxiety, fewer behavioural problems and more readiness to learn.

- For the older group (age 4 to 8), major improvements were achieved in children's emotional health and behaviour at the sites that used educational assistants to work with children in the classroom continuously from Junior Kindergarten to Grade 2.

- The site that yielded more positive outcomes for both children and parents than any other Better Beginnings, Better Futures site worked directly and intensively for four years with children (in the classroom) and with parents (in their homes).

Special Education and School-Family Relations

Special education placements decreased in schools where educational assistants worked with children in classrooms. Parental satisfaction with the teacher and the school increased when the educational assistants actively reached out to parents to forge connections with the school and involve them in their young children's education.

Children's Physical Health

At the younger child sites, children had more timely immunizations at 18 months than the comparison neighbourhood and parents felt they had better access to professionals, such as doctors and social workers, for their children. In the older child sites, parent ratings of their children's health improved.

Parent Health and Well-Being

Smoking by mothers and others in the home decreased at all of the project sites. In the younger child sites, smoking rates among mothers dropped by 10% and in the older child sites by 20%. This is encouraging since smoking levels tend to be high in disadvantaged communities, and the long-term health effects of smoking are well known.

Neighbourhood Quality of Life

At all the younger child sites, parents reported increased safety in the neighbourhood when walking at night. Parents in two of these sites reported a general improvement in their neighbourhoods, including increased community cohesion, less deviant activity (alcohol and drug use, violence and theft), and increased satisfaction with their housing.

In the three older child sites, parents reported greater satisfaction with the general quality of their neighbourhood, and the condition of their housing. At two sites, children made much more use of playground equipment and recreational facilities.

Partnerships

The locally-run Better Beginnings, Better Futures organizations became successful catalysts for voluntary collaboration among service agency partners, resulting in improved service availability and accessibility, and the leveraging of additional resources for the disadvantaged neighbourhoods.

Relative Cost

The annual cost of Better Beginnings, Better Futures per child/family was relatively inexpensive (approximately $1,100 to $1,400 per child/family per year), compared to the cost of highly-rated U.S. demonstration projects (which ranged from $4,300 to $21,000 in 1997 Canadian dollars).

Project Development

Local projects need local participation to succeed, and meaningful resident involvement is not easy to achieve in high-risk neighbourhoods where residents are distrustful of governments and service agencies. Some of the considerations identified in the project development research of the Better Beginnings, Better Futures sites include the following:

- allow enough time to build trust and develop programs (at least three years for complex projects);
- provide support to communities to help with planning and organizational development;
- give communities a guidepost for local involvement (Better Beginnings, Better Futures called for a minimum of 50% resident members on all key committees);
- allow considerable local control and flexibility to tailor the organization and its programs to local needs;
- balance local control with clear project ground rules to avoid confusion and potentially conflicting priorities.

Conclusion

The eight Better Beginnings, Better Futures neighbourhoods should be proud of their accomplishment in meeting the huge challenge put before them – to develop a local organization with meaningful resident involvement, to design and deliver a range of programs for young children and parents, and to strengthen their local community and build partnerships with other organizations. The lessons being learned in the eight sites have much to contribute to other disadvantaged neighbourhoods searching for ways to foster the future well-being of their children and families.

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For more detail and discussion, please see the full report, Developing Capacity and Competence in the Better Beginnings, Better Futures Communities: Short-Term Findings Report, *November, 2000 available at http://bbbf.queensu.ca.*

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A-2

Prevention of Child Abuse

Implications for Policy and Practice

by Harriet MacMillan

There are four major categories of child maltreatment: physical abuse, sexual abuse, neglect and emotional abuse. Much of the research to date has focused on physical and sexual abuse, particularly with respect to prevention.[1] There is also an urgent need for investigation into the epidemiology of and interventions for neglect and emotional abuse. Recognition that society should protect children is relatively recent; it was only in 1874 that the first North American organization to prevent child abuse began. Not surprisingly, understanding child maltreatment as a major public health problem is a concept that has developed over the past two decades.

The public health approach[2] highlights the need to think about the following questions in moving from the problem to the response: 1) What is the problem? (surveillance); 2) What is the cause? (risk factor identification); 3) What works? (intervention evaluation); and 4) How do you do it? (implementation).

What is the Problem?

Data from the Canadian Incidence Study[3] regarding reported cases of child maltreatment and information from community-based prevalence surveys, such as the Ontario Health Supplement to the Ontario Health Survey,[4] indicate that exposure to child maltreatment is common in Canada, and frequently undetected. Based on the Supplement, approximately 31% of males and 21% of females reported exposure to physical abuse in childhood; the rates for child sexual abuse were approximately 4% and 13% respectively. Much less is known about the prevalence of neglect and emotional abuse. Several reviews have emphasized the impairment associated with child maltreatment that occurs in the following domains: physical, emotional, cognitive and social.[5,6] Longitudinal studies are needed to determine the pathways between exposure to maltreatment and subsequent outcomes; much of the literature to date is based on cross-sectional data.

What is the Cause?

It is now known that the causes of physical abuse and neglect are many; there appears to be a strong link to factors associated with decreasing supports and increasing stressors. Little is known about the specific factors that lead to child sexual abuse, and the cause of emotional abuse has not been well studied. For physical abuse and neglect, most of the factors identified are risk indicators – associated with an increased likelihood of child maltreatment, rather than causal risk factors – that change the risk of abuse or neglect when manipulated. Risk indicators for child physical abuse include such parental factors as history of physical abuse in childhood and spousal violence, and such social factors as low socioeconomic status. General indicators for child sexual abuse include familial factors such as living in a home without a natural parent, and poor relationships between parents. Only studies with a longitudinal design will provide information about which indicators are actually causal risk factors.

With the identification of risk indicators, came efforts to identify people at increased risk for committing maltreatment – specifically physical abuse or neglect. The Family Stress Checklist[7] and the Adult-Adolescent Parenting Inventory[8] are examples of such screening approaches. Their main problem is a high false positive rate; a substantial number of individuals identified by such techniques as being at risk for committing child maltreatment would never go on to do so. Such labelling may subject people to increased stress and impair their ability to function as parents. According to several authors, including the Canadian Task Force on Preventive Health Care,[9] accurate prediction of individuals at risk for child maltreatment is not possible

What Works?

While interventions can include both treatment and prevention approaches, this presentation focused on prevention. Although these two categories may seem distinct, there can be considerable overlap. For example, an intervention that aims to prevent recurrence of child physical abuse of one child (often considered a type of treatment), is also a form of tertiary prevention. Furthermore, an intervention targeted for the overall family may have as a goal the prevention of abuse among other children in the family (some would refer to this as a form of secondary prevention). Offord and colleagues suggest that a more useful approach in considering interventions is to describe who receives it and under what conditions.[10] He encourages the use of such terms as targeted to describe those programs aimed at high-risk groups or individuals, and universal to indicate interventions that focus on communities, or certain populations (for example, youth within school settings).

To determine the effectiveness for interventions aimed at preventing one or more types of child maltreatment, a systematic review was carried out in 1994[11,12] and updated in 2000.[9] Only studies that included a control group were included in the review. Two main categories of interventions were identified: 1) perinatal and early childhood programs, and 2) education programs. The first category included targeted programs that were typically aimed at preventing physical abuse and neglect among socially disadvantaged families. The second group of programs, which were universal in nature, were focused on preventing child sexual abuse or abduction.

Perinatal and Early Childhood Programs

Studies that used reports of verified or suspected child maltreatment as outcome measures, or actual events such as emergency room visits or injuries, were included for review. Eight types of interventions were evaluated in controlled trials: 1) home visitation; 2) a comprehensive health care program; 3) a parent education or support program; 4) a combination of services including case management, education and psychotherapy; 5) intensive contact with a pediatrician and home visits; 6) extended parent-child contact following delivery; 7) free access to health care and 8) use of a drop-in centre. Of these interventions, only one specific type of home visitation – the Nurse Home Visitation Program (NHVP) developed by Olds and colleagues,[13-15] has been shown effective in preventing child abuse and neglect.

The NHVP is an intensive program provided to socially disadvantaged first-time mothers prenatally and extending until two years after the birth of the child. Nurses visited weekly until six weeks after delivery, every two weeks until the child was 21 months of age, and monthly until the child reached two years of age. The nurses focused on developing parental resources influencing maternal and child health, promoting empathic care, and linking families with health and human services. This program was first evaluated in a randomized controlled trial in Elmira, New York,[13,14] and then replicated in Memphis, Tennessee.[15] The 15-year follow-up results from the Elmira study showed that reports of child abuse and neglect among women who received nurse home-visitation were significantly fewer in number than among women in the control group.[14] At two-years follow-up in the Memphis trial, children whose mothers were visited at home had fewer health care encounters for injuries and ingestions compared to those whose mothers were not visited.[15]

Some have suggested that other types of home visitation programs are effective such as the Hawaii Healthy Start Program and the Healthy Families America Program, which both involve paraprofessional (lay home visitors) interveners. However, to date, the evaluation studies using a control group have not been shown effective in preventing child and neglect.[16,17] Further, a randomized controlled trial conducted by Olds and colleagues comparing nurses with paraprofessionals, showed nurses to produce a "larger and broader range of beneficial effects" compared with paraprofessional visitors in areas such as infant caregiving.[18]

While the NHVP by Olds and colleagues is the only program shown effective in preventing child abuse and neglect, and specifically among first-time disadvantaged mothers, it is encouraging that an effective intervention to prevent child maltreatment exists. Although the search for additional strategies needs to continue, this finding is an important scientific development in the field of child maltreatment and for child health generally.

Education Programs

Most education programs are school-based (universal), and aimed at teaching children to avoid sexual victimization or abduction.[12,19] Several sexual abuse prevention programs have been shown to improve knowledge about sexual abuse concepts and prevention skills, yet no study has shown that such interventions actually lower the occurrence of child sexual abuse.[9,12] Such programs may be more useful in helping children disclose sexual abuse that has already happened and in preventing it from recurring. In a cohort study involving a nationally representative sample of youth, Finkelhor and colleagues found that at one-year follow-up, children exposed to school-based prevention programs reported that they were more likely to disclose exposure to child sexual abuse.[20] Participation in the prevention programs was not associated with any decrease in overall self-reported sexual abuse.

It is important to highlight the emphasis these programs place on children to avoid sexual abuse. There has been a much greater focus on development of programs that place the onus on children, rather than on persons committing the sexual abuse.

How Do You Do It?

Once a program is shown to be effective, how should programs be implemented? Unfortunately, the overwhelming pattern in health and social services, has been to implement a program, and indeed disseminate it, before it has been evaluated. There are many examples of child abuse prevention programs being implemented without any evidence of effectiveness. Service providers and policy makers must resist the temptation to disseminate a program before there is evidence of effectiveness, based on rigorous designs.[1]

Olds' resistance to efforts to disseminate the NHVP before there was good evidence of its effectiveness provides an important example. He has underscored that dissemination of an effective intervention (to date only the NHVP) should adhere to the original program.[21] Too often programs are altered while being implemented.

Sexual abuse prevention programs must be evaluated as to whether they actually reduce the incidence of child sexual abuse. Because this type of intervention has been so widely disseminated and promoted publicly as helping to keep children safe from sexual abuse and abduction, it may be difficult to recruit subjects to conduct a randomized controlled trial.

Future Directions

There is now good evidence for the effectiveness of the NHVP model in preventing child abuse and neglect among first-time disadvantaged mothers. It is high time that this intervention is implemented in Canada with careful evaluation of the implementation efforts to determine if the positive findings persist with dissemination. Olds and colleagues are working with state and local governments in the United States to ensure that fidelity to the original model is maintained. To date, the NHVP is not available in Canada, and other home visitation programs are being touted as effective, when there is insufficient evidence to support such claims. The other programs that are being developed to prevent child maltreatment must be rigorously evaluated before any decisions are made about implementation. Child sexual abuse prevention programs are a case in point: these have spread throughout Canada, yet it is not known whether they actually prevent child sexual abuse.

Greater understanding of the distribution and determinants of the subtypes of child maltreatment is essential in developing models for additional interventions. For example, investigation into children's exposure to spousal abuse is a critical area of research. Ideally studies should employ longitudinal designs to identify causal risk factors. There must be a commitment to use of rigorous methods in evaluating preventive interventions; only then will there be valid data available about strategies to prevent child maltreatment.

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A-3

Low Income and the Impact on Child Development

by Tanya Faure, Satya Brink, Rob Santos, and Eva Lazar

As part of the Centre of Excellence for Early Childhood Development (CEECD), the Applied Research Branch of Human Resources Development Canada is Chair of the Policy Committee, whose objective is to access policy interventions and directions in order to characterize their general impact on child development. This presentation isolates the focus to a specific topic related to early childhood development: low income. It provides an overview of what is known about the impact of low income on child development, as demonstrated through national initiatives such as the National Longitudinal Survey on Children and Youth (NLSCY). Further, the presentation highlights how these findings influence policy development at all levels – federal, provincial/territorial and within communities.

The National Longitudinal Survey on Children and Youth (NLSCY)

The NLSCY is an outcome-oriented instrument that was implemented in 1994 as a means of providing comprehensive and objective information on how well children are developing in Canada. The impact of low income on child development was analyzed using data from the survey in several research projects. The results are summarized in three major findings:

1. Although there was a relationship between low income and low outcomes, the effects were not as strong as expected.
2. Children with low outcomes were not exclusively in low income families but rather they were found across every income category.
3. The probability of resilience was lower among children from low income families.

Traditionally, there was believed to be a strong correlation between low income and poor child development. However, although the probability of being vulnerable is higher for children in low income families, approximately one fifth of the children surveyed in high income families were also considered vulnerable. Children with poor outcomes are distributed throughout the income range; thus, although income is influential to a child's development, there are other factors that contribute to their developmental outcomes. For example, once having experienced disadvantages associated with low income, children living in low income families have a lower probability of "bouncing back" (resilience) compared with children living in higher income families. This is likely due to a cluster of factors associated with low income, (i.e., parental education, lone parent family, etc.), rather than the effect of low income on its own.

Because vulnerable children are found across all socio-economic groups, to maximize the potential of every child requires high levels of investment in universal interventions such as income support (e.g., National Child Benefit) and positive parenting programs. Inclusive and coherent policies and programs for families and communities, through joint action by different levels of government, can help children overcome disadvantages associated with poverty. Inclusive and coherent programs address multiple factors and, therefore, are the most important preventative and protective policy levers available to improve the outcomes of children.

Healthy Child Manitoba

In March 2000, the Healthy Child Manitoba (HCM) office was established as a means of bridging government departments and community partners within the province. Using this new way of working together, partners established a series of intersectoral and interdisciplinary structures from which an action plan was developed and implemented. The basis for these structures is a knowledge-action cycle that involves research initiatives (e.g., Understanding the Early Years community research project), policy interventions, practice and evaluation. This knowledge-action cycle allows for a child-centred approach to public policy.

Manitoba's approach has produced an early childhood continuum of policy, programs and services. This continuum includes nine separate yet interconnected initiatives that aim to improve the overall outcomes of children in the province of Manitoba. These initiatives begin in the early stages of a child's development, including prenatal development, and follow through the subsequent developmental stages of a child's life. For example, Healthy Baby; Parent-Child Centres; Manitoba Child Day Care; Education, Training and Youth ECD; and Children's Special Services.

A literature review by HCM supports results to those previously highlighted from the NLSCY. The key findings suggest that income can affect the overall life course of a child's development. This may require massive investments in programs such as income supports; however, the data also caution against targeting programs too narrowly given that there are socio-economic gradients in development that could result in a large number of vulnerable children being missed if programs are income specific.

HCM's work is an ongoing process that addresses emerging research questions and knowledge gaps. Through best policy mix studies, integration of economic and social programming and an interface with academia, Manitoba is working to improve the long-term outcomes of children.

The Centre of Excellence for Early Childhood Development (CEECD)

The Centre of Excellence for Early Childhood Development (CEECD) was established to promote the dissemination of scientific knowledge on the social and emotional development of young children and the policies and services that affect this development; and submit recommendations on the services needed to ensure the optimal development of young children.

Linking research to the implementation of service practices and/or policy development is at the core of the CEECD; ensuring these connections allows for a better representation of the issues relating to specific topics on early childhood development. These linkages will be captured in a series of two-paged summaries, authored by leading researchers and experts in a particular field, as part of an online encyclopaedia aimed at an audience of researchers, academics, service providers, service planners, policy makers and parents. These summaries will be representative of three varied perspectives: developmental, service provision and the implications for policy development. Each perspective highlights the existing and emerging trends and knowledge on a particular subject, with an added focus of incorporating how these trends influence the other perspectives.

Although each perspective works independently, they are interconnected through the CEECD and a common overarching theme relating the current empirical evidence with child outcomes. The first three topics undertaken in this process are: parental leave/stress; tobacco use; and low income. The scope of the research involved includes an international, as well as national, dimension to allow for relevant comparative analysis to be made on Canada's progress. This project is a five-year initiative.

Conclusion

Over the course of the three presentations, it was established that low income is a determinant of a child's outcomes and development, but that it is not the only one. To put the impact that it does have in context, joint initiatives, varying from research to policy and practice, have been developed and undertaken at all levels of government.

These interventions are holistic in nature, focusing on the child and children's development at each stage of their development. The CEECD provides a forum for discussion and dissemination of these interventions and their results to ensure that what is known now can impact the directions taken in the future.

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A-4

Rallying the Community to Improve Child Development

by Pierre Lapointe and Nathalie Bastien

Two projects aimed at rallying the community to create better conditions for child development – 1,2,3 GO! and Understanding the Early Years (UEY) – are currently being carried out in the Greater Montreal area. Descriptions of these projects are presented as input to discussion on the applied research and action program issues involved in mobilizing society to become more involved with the welfare of young children.

The 1,2,3 GO! Project

The 1,2,3 GO! project, an initiative of the United Way of Greater Montreal and its partners, aims to make communities more inclined to apply their abilities and resources to foster a culture that takes child welfare seriously and reflects this concern in how its members think and act. The project attempts to achieve this by inviting all community members to share a common concern – to provide every child with the same chances of success and to create the favourable conditions needed to create environments that are conducive to children's all-round development.

Since the welfare and optimal development of children result from the interaction of a number of individual and environmental factors, 1,2,3 GO! encourages communities to use three main strategies – enhance potential, enrich social environments and apply community influence – and to focus simultaneously on a massive scale on several target areas. In addition, communities are encouraged to make decisions and choose lines of action based on these guiding principles:

- Promote as much collaboration as possible so that families can take advantage of resources and services that are better integrated and coordinated
- Canvas children and their parents directly

- Publicize quality activities and services that are directly for children
- Promote various forms of support for parents and encourage them to play an active role in the project
- Make sure that social practitioners are well-qualified and provide quality service.

Funded by the private sector, the 1,2,3 GO! initiative is currently set up in six urban, suburban or rural neighbourhoods in the Greater Montreal area, each of which is monitored and scientifically assessed.

At the local level, the project is sponsored by consortia of individuals, parents and decision-makers from all walks of life. These consortia are directed by the project leader to:

- Adopt the recommended strategy and guiding principles as listed above
- Share a common vision of what they would like to offer the young children in their communities
- Formulate an action plan based on local issues and priorities
- Provide concrete support to implement the action plan.

Although all the local projects adopt the same common philosophy, each one has its own way of interpreting and implementing 1,2,3, GO!

The action plans of local consortia have generated several activities that directly foster child development and effective parenting. In addition, several child-welfare strategies have been promoted to:

- Enrich the social networks that parents function within
- Make sure that resources and services are more accessible and available
- Empower parents to take action and become more involved
- Increase the feeling of social belonging and cohesion
- Provide safer and more suitable physical environments
- Encourage pro-children values
- Maintain closer overall cooperation.

In the last five years, we have noticed that:

- Residents of neighbourhoods where the project is taking place have become more sensitive and involved vis-à-vis young children
- Community leaders have made child welfare a top priority
- Partners from the various sectors collaborate more and have successfully learned how to work together
- Services have become more suited to the needs of children and parents.

Several factors seem to be associated with the success of such rallying activity, namely: the positive effect of shared, influential leadership; a range of partners with considerable resources; a specific place for parents, various support mechanisms for participants, and data available from different sources to guide decisions and orient action.

Some of the main lessons that have been demonstrated by the success of the 1,2,3 GO! project are that communities clearly can mobilize and get involved to improve quality of life for their children and provide them better conditions for development. As a result, a 1,2,3 GO! centre was recently created to provide resources and various forms of support to all the communities that have already mobilized to promote child welfare and ensure that every child gets a good start in life.

The Understanding the Early Years Project in Montreal

The UEY project is part of a federal Canada-wide program to foster child development and combat poverty. The aim is to provide local stakeholders with the means to assess the quality of child development in their respective areas and to identify local strategies that could improve the use of resources and programs. In Montreal, three main information sources make it possible to assess children's development in certain Montreal neighbourhoods when young children enter school for the first time. First, teachers assess the knowledge and skills of five-year-olds entering kindergarten. Then, the parents are surveyed for various types of information on their children's state of health and development. Lastly, a study is made of the programs and resources that are available for children aged under six and their families. All this information is provided to the community members involved with children to help them develop an action plan to improve local child development conditions.

This research project is sponsored by the United Way of Greater Montreal through the 1,2,3 GO! initiative, in collaboration with the Regional Health and Social Services Board of Central Montreal, the Île de Montréal Board of Education, the Montreal School Board and the City of Montreal. Funding comes from Human Resources Development Canada and Statistics Canada. The project began in 2000 and should continue over the next five years.

Several contemporary research studies have identified the risk factors in families' socio-economic conditions that are closely associated with how well children do in school and develop generally. In this connection, data from the 1996 Census have been used to measure how vulnerable specific local populations are in this regard. Compared with the child welfare pattern for Canadian society as a whole, the child welfare profile for the Montreal residents who were surveyed is clearly inferior in several key parameters. For instance, the children in the districts surveyed are more likely to live in neighbourhoods with more low-income households, more residents with little education, more single-parent families, higher turnover of residents, more immigrants, more allophones, more people whose main source

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of livelihood is government transfer payments, fewer active workers and fewer homeowners.

Assessing the scholastic ability and skills of children entering kindergarten provides several types of information. For instance, 70 kindergarten teachers in 28 primary schools belonging to the Montreal School Board evaluated 1,274 pupils on the basis of five child development factors that have been identified as having the most significant effect on learning and academic success: physical health and welfare; behavioural adequacy; emotional maturity; language development and cognitive skills; and communication and general knowledge.

Analysis of all the data gathered revealed:

- Most children get good results. However, 32% of the children surveyed fared badly in at least one of the assessment factors and 16% were negatively assessed in at least of two of the factors (beneath the 10th percentile).
- Generally speaking, girls performed better than boys in all factors.
- Overall, older children appeared to be better prepared than their younger counterparts to take on the challenges of school life.
- In general, allophone children (i.e., children that do not have French as their first language) fared worse than their Francophone counterparts.

The data from the latest assessment can be used to determine specific learning adequacy profiles for children and to identify a group profile for the student body of each participating school. Analysis of these data should enable local community members to determine to what extent children in their respective neighbourhoods are prepared to go to school. In addition, school administrators can use this information to identify the needs of children coming to the school for the first time and to modify their educational programs accordingly.

Representatives from the partner organizations form the research coordination committee for the Montreal UEY project. They supervise all information-gathering and research dissemination activities. At a more local level, information-exchange activities are organized with stakeholders from five Local Community Service Centres (CLSCs) in focus groups of representatives from local organizations that provide services to children and families.

The strategies used to share study findings depend on the organizational characteristics of each CLSC. In general, the stakeholders are invited to take part in meetings where they can learn about our findings and to exchange information on the quality of child development in their respective neighbourhoods. They can then use this information to revise their own action plans for children and families.

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Plenary workshops

Three questions relating to the workshop theme and which highlight key issues involved in implementing this type of project were discussed with the participants:

1. Why should we improve the quality of child development? We asked community members what importance they attach to child and family development. People's attitudes on this topic can vary greatly from one region to another; thus, it is crucial to be aware of prevailing attitudes in any attempt to mobilize local communities.
2. What is a community? Here we discussed geographical area (district or neighbourhood concerned) and identified key stakeholders (people or organizations).
3. How can a community help its children? We discussed what action has already been carried out in the community as well as what new initiatives should be taken to improve child development conditions.

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Nathalie Bastien, PhD (psychology) is coordinator of innovation, research and development at the 1,2,3 GO! Centre. The centre's mission is to provide resources and various forms of support to communities that want to get involved in supporting child welfare.

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A-5

Mobilizing the Community

In Support of Students in Poverty

by Nancy Halsall, PhD

One in five children in this country live in poverty. We know that poverty has an impact on readiness to learn, the ability to take advantage of the opportunities provided by the public education system, and eventual school success. Although school boards cannot tackle the root causes of poverty on their own, as policymakers at the local level, they can help reduce its impact and make a positive difference in the lives of these children and their families.

Over the past five years, the Canadian School Boards Association has been undertaking a comprehensive national campaign to assist school boards, in cooperation with other partners, in carrying out specific actions to address the issue of child poverty and its impact on school readiness and eventual school success.

Towards Awareness

Recognizing that awareness and a common base of information is an essential starting point for any action, CSBA released a resource book, *Students in Poverty: Toward Awareness, Action and Wider Knowledge*, in 1997. The handbook provided data on the pervasiveness of child poverty, summarized existing Canadian literature on the issue, profiled a number of innovative programs that have been launched by school boards across the country, and suggested strategies for school boards to undertake an assessment of the situation in their communities.

Interventions Profile

Although the face of poverty differs from region to region, CSBA recognized that there are common responses schools and school boards can undertake to counter its negative impact.

Through a review of existing school-based programs, and with the assistance of a team of advisors, CSBA developed the Poverty Intervention Profile. The purpose of the profile, a board assessment tool, was to:

- Help boards evaluate their efforts in establishing interventions for students in poverty.
- Improve existing intervention programs to better help students in poverty.
- Provide a model for the development of intervention programs in school boards that do not yet have them.

Mobilizing the Community

The development of the Profile was only the first step; encouraging boards to utilize it and assessing whether it really worked were the next. To achieve these goals, CSBA assisted ten school boards across the country in using the profile to mobilize their communities in support of students living in poverty.

The goals of the Mobilizing the Community project were to:

- Raise awareness about the importance of holistic interventions as described in the Poverty Intervention Profile.
- Support the mobilization of school boards, communities and other agencies in using a holistic approach.
- Establish pilot intervention sites across the country.
- Share the findings of the sites.

The results of this endeavour, the latest phase in CSBA's national poverty initiative, are summarized in the report, *Action Against Poverty: School Boards Making a Difference*. It provides an overall assessment of the project as well as an evaluation of the activities carried out at each of the ten sites:

- Lethbridge School District Number 51, Alberta
- Burnaby School District Number 41, British Columbia
- Coquitlam School District Number 43, British Columbia
- St. Boniface School District Number 4, Manitoba
- Avalon East School Board, Newfoundland and Labrador
- Halifax Regional School Board, Nova Scotia
- Conseil scolaire acadien provincial, Nova Scotia
- Eastern School District, Prince Edward Island
- Parkland School Division Number 63, Saskatchewan
- Kawartha Pine Ridge School District, Ontario

An outstanding commitment and effort were made by those involved in the pilot sites. The goals of the project were met and exceeded.

What We Learned

- When the CSBA, a national education organization, was involved in the project, it fostered a sense of commitment among the different school boards and leveraged other financial support. The attention and support of national agencies such as CSBA help schools and boards to maintain momentum in poverty intervention.
- Trustee involvement is critically important. Interest shown by trustees can offset the inability of senior staff to focus on preventive activities when besieged by crisis.
- Long-term commitment is necessary for boards to put in place a comprehensive approach to poverty intervention.
- The Poverty Intervention Profile does not seem to overlook any major area of poverty intervention. Even when the profile is not actually administered, it serves as a thorough outline of the elements necessary for poverty intervention.
- The experience and background of staff and principals assigned to schools serving students in poverty are important.
- Relatively small amounts of money can create leverage in school systems and communities.
- The role of schools in community development is little understood and is not widely accepted.
- Community agencies provide feedback and encouragement to schools in building and sustaining interventions.
- Evaluation is not widely understood as a means of demonstrating the worth and efficacy of programs when tight budgets threaten their continuation.
- Making progress on poverty intervention can be achieved only by keeping the issue on the table.

In addition to these general insights, specific suggestions for trustee action are outlined. The key role of school boards in developing policy is recognized and a poverty policy template based on the interventions profile is provided.

Detailed profiles of each of the ten pilot sites are included in the report. It is hoped that making information available about what some school boards are doing, about what worked and what didn't work for them, will encourage other boards to meet the leadership challenge and to mobilize their communities to both address and redress the impact of child poverty.

Dr. Nancy Halsall, PhD, is president of Halsall Measurement and Analysis Inc. She has collaborated with the Canadian School Boards Association since the inception of this project.

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A-6

Youth Engagement 101

What is it? How do we do it? What do we get out of it?

by Mark Pancer, Danny Breault and Lanny Jimenez

What is youth engagement?

There are many different perspectives on what youth engagement is, the ways in which youth show their involvement or engagement, and why they become engaged (or fail to become engaged) in the first place. This "engaging" seminar will outline the conceptual framework we, the Centre of Excellence for Youth Engagement, use to help us understand youth engagement. Based on discussions with youth, youth service providers, researchers, and the completion of an intensive literature review and program scan, we will share what we know about youth engagement, what we don't know, how we intend to find out more, and how this information may be used in the development of theory, programs and policy.

However, there is another story to be told here – the story of how adults and youth begin to learn to work collaboratively as true partners in understanding youth engagement. Throughout this workshop, we will highlight some of the things that we – the youth and adult researchers who are committed to this project – have learned about each other, and about how we can work together as equals, bringing our strengths together to do research in a new way that will allow us to gather information that will truly benefit youth.

Lesson 1 · Defining Youth Engagement

There are many ways to define or describe "engagement." One of the best ways is by means of a story. Our workshop will begin in an "engaging" fashion by having Lanny tell her own story of how she herself became "engaged" and how it affected her life. We will then invite the session participants to work in small groups to come up with their own definition of youth engagement, and share their definition with those attending the workshop. Following this, we will present our own initial definition of youth engagement (the "academic" one), highlight some of the comments, suggestions and critiques that have been made on-line among our partners about how youth engagement should be defined, and present some of the responses that youth across the country have made when we asked them to define youth engagement in individual or focus group interviews. Then, as a group, we will discuss the first main question of our workshop (Question 1, below).

QUESTION 1: How do we combine the needs of researchers for a definition that is meaningful to their research community with the needs of youth for a definition that is meaningful to the youth community?

Lesson 2 – Deciding What to Study and How to Study it

In order to become the "Centre of Excellence for Youth Engagement," the original partners in what was to become the Centre had to begin to think of what the focus of their research would be, and to suggest some possible studies to begin the work of the Centre. In our initial discussions, a group of adults and youth working as both program people and researchers tentatively mapped out some initial research projects. We began with a rudimentary conceptual model that Mark had developed with a colleague from research he had done concerning youth volunteering. The model is a simple one. It proposes that youth first become engaged for one of three major reasons (which we refer to as initiating factors): because they want to get something out of it (e.g., have fun, fill a gap in their lives); because of their own beliefs or motivations (e.g., because of a sense of responsibility to others); or because someone encouraged them to get involved (e.g., a friend or adult mentor).

What is really important, however, is what keeps them engaged once they have started (which we refer to as "sustaining" factors). These sustaining factors include the support of family, friends and others, and the positive outcomes that youth experience through their engagement (e.g., feeling like they've made a difference, feeling respected). At the same time, there are factors (which we have termed "inhibitory" factors) that can make it less likely that a youth will stay engaged. When a youth has experienced sustained engagement, she or he begins to really benefit from some of substantial outcomes.

Given this conceptual framework and our interests as a Centre, we began with a series of research projects that we thought would help us answer some key questions, such as: how can we get more youth engaged?; how can we change things so that the "systems" in our society (e.g., schools, government, agencies) are more accommodating to youth, and incorporate a youth perspective into their policies and programs?

We decided on three major research projects:

1. Literature Review and Program Scan

One of the initial activities of the Centre of Excellence for Youth Engagement was to conduct a thorough review of the research literature. We (the Centre's partners) have developed a detailed on-line data-base that we have used to enter over 100 articles from scholarly journals and other sources, on the topic of youth engagement. These articles focus on issues such as factors that promote or inhibit youth engagement, the degree and nature of youth engagement, and the impacts of youth engagement on the youth themselves, and on the schools, organizations, and neighbourhoods in which they live, study and work. We also began a scan of youth programs, in an attempt to identify the key features of programs that were successful at engaging youth. To date, over 75 programs have been entered into our data base.

2. Narrative Study of Youth Engagement

Another of the ways in which the Centre of Excellence for Youth Engagement attempted to understand what youth engagement was, how it affected youth and how it could be enhanced, was to interview youth across the country to ask them to describe the ways in which they were (or were not) engaged and some of the things and people that helped or hindered in this process. We will present some of the results of these interviews, which were not only conducted with youth, but by youth interviewers. Lanny will give her perspective on what it was like as a youth interviewer, and Mark will discuss the creation of the interview schedule and the training materials for youth interviewers. We will highlight some of the differences in the perspectives of youth and researchers, and how these differences were (or were not) reconciled to this point.

3. A Longitudinal Study of Youth Engagement

This study is designed to assess the impact of youth conferences on youth engagement and adjustment. The plan was to administer a questionnaire that assessed levels of engagement, along with several measures of adjustment, to youth who had applied to attend a summer conference that focused on youth involvement in social justice issues.

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The youth who were accepted for the conference would form our "intervention" group, while those who were not accepted were to form the "comparison" group. We plan to follow both groups for the next three years, sending questionnaires to each at yearly intervals.

The background story to these projects is how youth were (or were not) involved in the development of these research plans. While the meetings in which we developed these first research initiatives involved a few youth, in the initial stages there was relatively little participation in developing the research plans for the centre. We will describe some of the problems that occurred as a result, and how we've attempted to deal with them. As a group, we will discuss our next major question:

QUESTION 2: How can researchers and youth work collaboratively, as a team, to select the questions to address in our research?

Lesson 3 - Analyzing, Interpreting and Communicating Results

We are now in the process of analyzing and interpreting the results from the review of the research literature, the program scan, the narrative study, and the first phase of the longitudinal study. We will present some of the initial results of these efforts. We will also, again, talk about how adult researchers, program people, and youth have worked together in this process.

QUESTION 3: What should the roles of adult researchers, adult program people and youth be in analyzing research information, interpreting and communicating research results?

Conclusions

We hope that those who attend this session come away with some information about youth engagement, and what we have learned about engagement from our research projects. We hope that they will also have begun to think of research in a new way, as a process that can be, in and of itself, "engaging" for youth.

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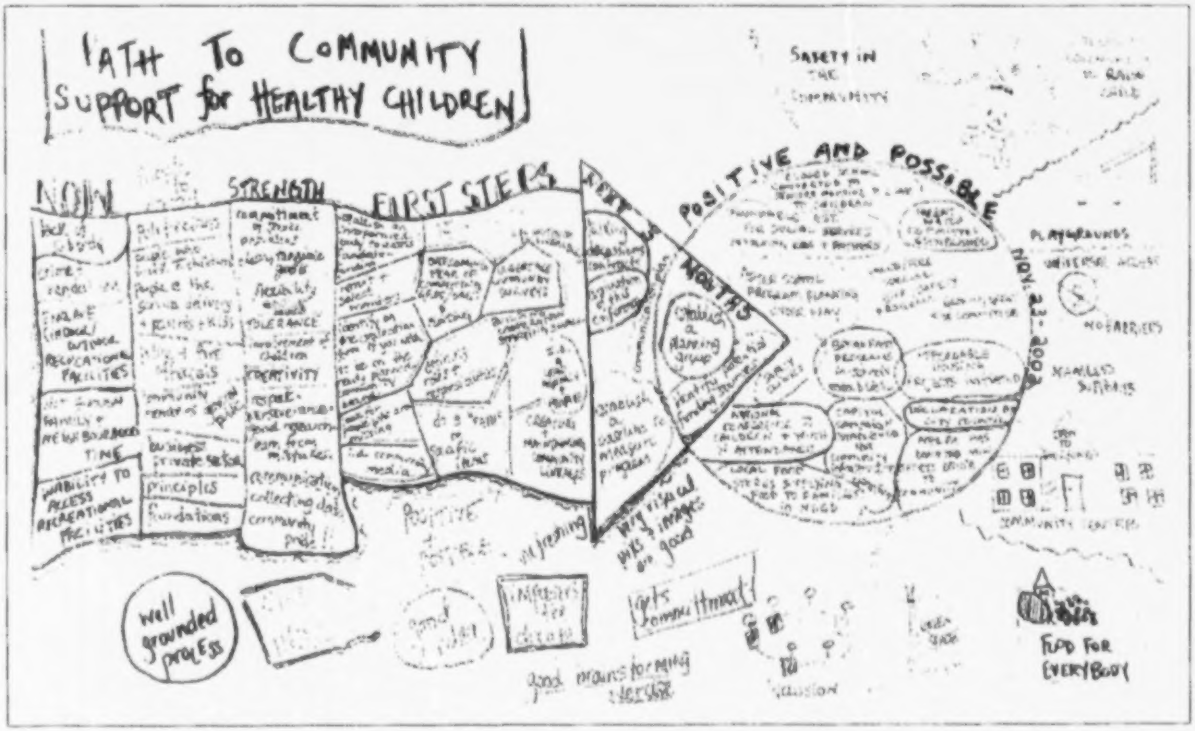
A-7

Path Planning

Translating Good Ideas into Practical Solutions that Work

by Wayne Helgason

PATH (Planning Alternative Tomorrows with Hope) is a planning process/tool that has been dramatically growing in use within the community and voluntary sectors. It has been found to effectively level the playing field between professionals and the grassroots community. The product, which is prepared together and complete at the end of the session, is left with the group and can be explained easily by members of the planning group. The basic steps are as follows:


PATH TO COMMUNITY SUPPORT for HEALTHY CHILDREN
NOW
STRENGTH
FIRST STEPS
NEXT 3 MONTHS
POSITIVE AND POSSIBLE
NOV. 22, 2002
SAFETY IN THE COMMUNITY
PLAYGROUNDS
TOLERANCE
CREATIVITY
principles
foundations
well grounded process
FOOD FOR EVERYBODY

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1. Shapes or Visions

The group Shapes or Visions a future focused on a long term and sometimes unrealistic view (why not dream sometimes?). Its heavy use of visuals reduces linguistic barriers, achieves easier consensus and is engaging and fun.

2. Planning Backwards

The process of planning backwards begins next. First, we look at one or two years ahead. The test is to achieve what is "Positive and Possible." This is recorded in the circle.

3. Reality Check

Next, we move back to be "grounded in the now." The challenges we face, the circumstances of concern are noted from the group.

4. A Practical Plan

From this point we move ahead to peruse the ideas in the circle being guided by the vision at the far right – but how? Who must we enroll? Who needs to know or be involved if we are to be successful?

5. Strengthen the Plan

After identifying ourselves and others, we agree on what will strengthen our chance of success and agree on these factors.

6. Some Action Steps

Some steps towards action have emerged. Up they go into the arrowhead and this becomes our shorter term plan.

*7. **Lets Go!!!***

The last step is the first steps we must take and by who.

***Additional resources on the process can be accessed from** www.inclusion.com*

Wayne Helgason is the Executive Director of the Social Planning Council of Winnipeg and an ex-officio member of the managing committee for the Centre of Excellence for Child and Youth Centred Prairie Communities.

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A-8

Links Between the Study of Child Maltreatment in Quebec (Étude d'incidence québécoise – ÉIQ) and Social Policy and Practice

by Micheline Mayer

The overall aim of the Quebec study (ÉIQ) on the incidence and characteristics of cases of abuse, negligence, abandonment and serious behaviour problems reported to the Quebec Youth Protection Branch (DPJ) was to prepare a detailed description of the children and families concerned. More specifically, the objectives of the ÉIQ were to:

- Estimate various types of incidence rate for cases reported to the DPJ in terms of various forms of maltreatment and serious behaviour problems
- Record the nature and gravity of the problems reported
- Characterize the client groups involved and describe the services provided in the weeks following the initial reporting.

The study, which documented approximately 10,000 cases reported to the DPJ between October 1 and December 31, 1998, was led by three senior researchers: Marc Tourigny (*Université du Québec à Hull*), Micheline Mayer (*Institut de recherche pour le développement social des jeunes* and *Centres jeunesse de Montréal*) and John Wright (*Université de Montréal*). The team worked in consultation with an advisory committee consisting of research associates Camil Bouchard (*Université du Québec à Montréal*), Claire Chamberland (*Université de Montréal*), Richard Cloutier (*Université Laval*), Chantal Lavergne (postdoctoral researcher) and Thomas Lebeau (service quality manager at a youth services centre in Quebec).

Even before the final research report was published, the data it contained were used to respond to requests from political circles and to meet high-priority practical planning and scheduling needs. Two examples of how these analytical data were used are:

1. A social disadvantage index was created as a predictor of resource needs in the youth sector. This was particularly useful because the relative allocation of budgetary resources for youth social services between the various administrative regions in Quebec has traditionally suffered from a lack of needs indicators. There has been no uniform information-gathering process for management purposes and the geographic areas involved have been too large to serve as a solid basis for planning and organizing.

Since the incidence study characterized cases of children and families that were reported for small geographical areas, it helped to quantify a predictor of social service needs in terms of family poverty as well as to propose a way of taking this factor into account when allocating individual budgets.

In the first place, analysis of ÉIQ data established a significant connection between the rate of child welfare cases reported in Quebec's 168 territories with CLSCs and three socioeconomic characteristics of families in these areas as expressed in the 1996 census. These characteristics are: the percentage of low-income families; the percentage of single-parent families; and the percentage of parents without high-school education. The analysis showed that there was a very strong connection between these socioeconomic variables and the rate of reported cases in highly or moderately urbanized communities but a weak connection in rural communities. This observation is explained by the fact that there is very little apparent difference in socioeconomic variables in rural communities, which also usually cover a very large geographical area. To do justice to the rural areas, the second phase of analysis examined the situation of families in these areas.

The analysis thus focused on connections between the three socioeconomic variables for families and the risk that these would result in a case being reported to the DPJ. Cross-tabulation tables were ordered from Statistics Canada so as to determine not only the relationship between each characteristic and the dependant variable, but also any relationship between all combinations of these characteristics.

This approach revealed that urban or rural residence is not a factor that affects the likelihood of having a case reported to the DPJ. On the other hand, low income, a low education level, or single-parent families are risk factors whose effects vary depending on the various possible combinations. For example, a two-parent family with an annual income of over $15,000 and with both parents having a high school education or better have 2.19 chances in 1,000 of having a case reported, but this likelihood increases to 40.8 out of 1,000 for low-income, single-parent families with a low education level. The analysis shows the relative degree of risk for children of the various possible combinations of socioeconomic characteristics between these two limits.

In this way, the ÉIQ has made it possible to measure to what extent certain families' social disadvantages affect a specific needs indicator – i.e., the incidence of a case being reported. Based on these findings, it has also been possible to propose a way to include this dimension in allocating youth services budgets for the various regions.

2. Another way the data were used was in an analysis of the sources of variation in the professional activity that takes place in youth services centres.

A report on the clinical organization of youth services commissioned by the Quebec Department of Health and Social Services and prepared by an expert group contains the following averages for professional activity in youth services centres:

- Reportings accepted for follow-up (49%)
- Cases validated after assessment (42%)
- Assessment timeframe (28 hours)
- Court referrals after assessment (44%)
- Timeframe for taking action (711 days)
- Court referrals relating to action taken (75%).

The report shows how each youth services centre fares in relation to these averages and, as might be expected, some centres come out better and others come out worse. Since the report gave no other explanation for the variations, it has been suggested that the variations might not be justified – a situation that has given rise to considerable soul-searching in Quebec's youth services centres.

The new data contained in the study could be used to check whether some of these variations are due to particular characteristics of the client groups or in the cases reported to the centres. Indeed, it is possible that some youth services centres proceed differently because their client groups or the cases they receive have specific characteristics different from those found in other centres.

Analysis shows that specific variations noted by the report disappear when the characteristics of the client groups or of the reported cases are checked. On the other hand, this verification process also shows that there is indeed variation in some parameters that were previously presented as the same.

Two examples of this for a specific centre involve the percentage of reportings accepted for follow-up and the percentage of cases where a child's safety or development was actually compromised.

In all the youth services centres, the following factors are associated with a decision to accept a reported case for follow-up:

- The parents have a higher level of need
- The child has a higher level of need
- The child lives in a reconstituted or single-parent family
- In cases reported by a family member, there is no custody dispute. The case has been reported by a public source
- The child was reported only once in fall 1998
- The child is under 6 years of age
- At least one other child in the same family has been reported.

In the case of this particular youth centre, the acceptance rate, according to the expert group, was 53%, compared with an average of 49% for youth services centres in Quebec as a whole — in other words, its acceptance rate was higher than average. On the other hand, the analysis found that there was no significant difference between the acceptance rate for this centre and that of the others, once the characteristics of the client groups and the cases being reported had been checked.

The factors associated with determining cases where a child's safety or development has been compromised are:

- More child needs are observed
- The harmful situation has lasted for more than 6 months
- Other harmful situations exist for the child
- Parents have higher needs
- The child is aged under 4 years or over 15 years
- The parent is not sufficiently cooperative
- The accommodation is not safe
- The child has already been taken in by child protection services
- The child has been reported on more than one occasion during the study
- The reported case involves child abandonment
- The parents are seen to have more problems.

In the case of the youth services centre referred to, the rate of cases where a child's welfare was actually compromised was 43%, according to the expert group, compared with an average of 42% for all centres. There was thus no major discrepancy. On the other hand, the analysis showed that after the characteristics of the centre's client groups and reported cases were checked, the centre ended up with a rate of cases of compromised child welfare that was actually 6% more than the others.

It thus emerges that ÉIQ findings can explain certain variations in youth services centre practices but these are not necessarily due to any failure to follow proper procedure.

Conclusion

The Quebec study provides an abundance of new data in the form of detailed descriptions of the characteristics of children and families reported to the province's youth protection services. The study also describes the problems children and their parents have experienced and the various decisions taken during the period the children were subject to in-depth assessment. These data have indicated how to take the factor of families that are socially disadvantaged into account when allocating budgets for youth services and how to analyse the link between the characteristics of clients of youth services centres and decisions made concerning these clients. The study has thus helped clarify certain questions relating to planning and organizing social services. The study documents situations that could not have been analysed until now because of constraints inherent in management data and clinical research samples.

Micheline Mayer is a researcher for The Institute de recherche pour le développement social des jeunes. Her interests include child neglect, geographic distribution of poverty, social and psychosocial problems, the epidemiology of child maltreatment and violence perpertrated by youth.

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B-1

Moving the Public Policy Agenda

Effective Government/Voluntary Sector Collaboration

by Peter Dudding and Ron Stanley

It can be argued that the information revolution has caused organizations to be less well informed than previously. Although there is more data (to be sure) the information most readily available is internal and the most important changes to affect social institutions are likely to be external. It is also true that organizations must be globally competitive, even though they may operate only in local markets. Information technology has had the hugely important effect of spreading knowledge instantly with much greater accessibility, increasing both the level of awareness and expectations.

In order to succeed in this new environment, every organization will need to turn itself into a change agent. This will require them asking "what outside information do we need," and devising proper information systems to collect this information about the outside world.

Policy development work at both the federal and provincial levels can be seen as a "marketplace" where regular interaction and transactions occur between key players. As such, it is a complex and competitive environment, which requires planning, information-gathering and relationship-building to have an impact on the decision making process. There are multiple opportunities for interaction and engagement at both the political and bureaucratic levels to influence what ultimately become political decisions regarding the commitment and use of resources.

There are many definitions of policy. Ours is "the intention and direction emerging from values and vision for a better future and to resolve opposing interests and problems." Tools for the development of policy options include:

- Consideration of different values
- Goals
- Projections and forecasts
- Scenario of alternative visions
- Plans to get there
- Consensus building
- Design and testing of options

The Canadian tradition is to consider policy options, which are usually based upon essential facts, choices, costs and impacts, in order to determine the best available option.

The Canadian child welfare system has been faced with a number of problems in its policy development capacity. The "system" is actually thirteen small systems in a highly decentralized federal state, with each province and territory responsible for its own legislation, policy and funding. This has resulted in limited resources for information gathering and for comparing outcomes nationally or internationally. The issues involved in child welfare, including child neglect and abuse, are complex and connected to many other social factors such as poverty, mental health, other services and supports, and human development. The nature of the child welfare service systems have tended to be reactive and crisis-focused, and, in the absence of good information, decisions are based upon emotive rather than rational decision-making. There has not been a strong research tradition in child welfare services, so that practice is not "evidence-based" and outcomes are largely unknown. There has been a fair degree of skepticism at both the public and political levels about the effectiveness of these services, and a strong need for better information and research. In an environment that places an increasing emphasis on effectiveness, efficiency and accountability for scarce public resources, there is an urgent need for a pro-active approach to public policy development.

The reality for child welfare in Canada is that the government/voluntary sector partnership is only at a beginning developmental stage. However, there is a growing recognition on the part of both partners of the importance and mutual benefit of developing this partnership. As the expectations regarding accountability for resources used and results achieved continues to grow, along with the need for greater transparency in decision-making, this partnership will be of increasing value. The objective for the voluntary sector is not just to influence government decision-makers but to also impact on public opinion and the business sector.

The key challenges for voluntary sector child welfare organizations will be to continue to develop their capacity not only to focus on ameliorating social problems and providing services to children and families. They will also need to place a greater emphasis on systemic and preventative activities – research, collaboration and communication. These three activities are interactive and connected in order to create a knowledge-based and participatory organization, which has the capability of communicating its key messages.

TABLE 1

Research	Collaboration	Communication
identifying issues	identifying partners	information sharing
gathering information	engaging participants	awareness building
building knowledge	building consensus	advocacy
analysis of information	creating common agendas	mobilizing
outcomes	developing action plans	

It is also critical that these activities be based upon a central child rights/child development focus, as the overall vision of the organization.

The information age creates great challenges and opportunities for organizational change, which can in turn impact upon public knowledge and values. This marketplace is very volatile and competitive, and will require thoughtful and strategic planning in order to succeed.

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B-2

Towards a National Children's Agenda

by Dianne Bascombe

Governments in Canada have clearly indicated their collective commitment to improving policy and programs for children and youth through the National Children's Agenda (NCA) and Early Childhood Development (ECD) agreements. In the fall of 2000, the federal government pledged $2.2 billion over five years for early child development programs to: promote healthy pregnancy, birth and infancy; improve parenting and family supports; strengthen early childhood development, learning and care; and strengthen community supports. The federal funding began in April 2001, using the Canada Health and Social Transfer (CHST) as the funding mechanism.

Within the ECD agreement, First Ministers acknowledged the need to be publicly accountable in their commitment to provide:

- annual reports beginning in 2002 on investments and progress from an established baseline of expenditures and activities;
- a shared framework of agreed upon comparable indicators for the expenditures and activities;
- regular reporting on child well-being using agreed upon common outcome indicators.

These agreements have critical implications for the delivery of services at the community level. The CHST is a block funding mechanism to transfer federal resources to provincial/territorial jurisdictions in health, education and social services. The use of the CHST as the funding mechanism for the ECD increases the importance of public accountability regimes. Through the annual reporting from established baselines, governments can be held to account to ensure that ECD funds are actually being spent in the four priority areas identified in the agreement.

The purpose of the baselines is to identify current spending on all ECD programs and services for 2000/2001 prior to the new federal dollars entering the system via the CHST. It is critical that baselines are clearly reported and easily understood so that communities and organizations can track funding by jurisdiction. There will be challenges in defining the boundaries of ECD. When governments make public their baselines in September 2001, we cannot expect consistency in reporting across jurisdictions, which in turn will make it difficult to make comparisons.

Beyond the simple expenditure of federal dollars within the parameters of the ECD agreement, the Social Union Framework Agreement (SUFA) speaks to "ensuring access to reasonably comparable services." The tracking of funding investments by activities and programs will enable a picture of available services for ECD to come into view. The ECD agreement holds provincial/territorial governments to spending in any or all of the four priority areas – but it is a menu of services rather than a basket. To develop social programs that are truly accessible, we need to encourage governments to invest in all four areas of the ECD. It is difficult to imagine an effective system of ECD at the community level without regulated child care.

To compare services, we also have to look beyond mapping what exists. What we now know about effective programming and about best practice in service delivery provide some tools for a systemic approach to assessing services and programs for "reasonable comparability." When you move to a new community in Canada, you would hope to find a familiar basket of services to meet your family's needs. Thus, we need public dialogue on what works at the community level to scope out what Canadians believe should be the core of public services.

It is critical that we track child outcomes at the community level. This will provide us with an important public policy tool. The ECD agreement and its commitment to child outcome indicators is an opportunity to continue the Canadian research and data collection that has begun. In the voluntary sector, recognizing that this work is in its infancy provides an opportunity to engage governments in an ongoing process of this development.

All these recent government agreements include common themes of transparency and process. In the area of reporting to the public, the ECD agreement will set the standard for the future. As the levers for social policy at the federal level shrink, the importance of public reporting cannot be overstated. And as leaders and organizations in the voluntary sector, we have a role to play in gaining access to these new decision-making processes. As monitors, we need to ensure that the indicators used are understood to be "works in progress" that can be updated to respond to new research and emerging issues. It is time for us to be at the table.

The implications of the ECD agreement extend well beyond services for early childhood. Next year, SUFA will be reviewed – and the ECD agreement is the major inter-governmental initiative under SUFA. Indicators and monitoring have replaced federal spending power and cost-sharing as levers for national policy. If we want a sustainable national infrastructure for health and social services across jurisdictions, now is the time to bolster the policy research capacity of the voluntary sector. This will enable our effective participation in these complex inter-governmental policy-making processes.

The challenges of having an impact on the upcoming inter-governmental work on indicators and outcomes for the ECD are significant, yet we have to keep trying to influence the process and the content. One of the strengths of the National Children's Alliance is its capacity to mobilize diverse communities for dialogue, policy development and action on issues impacting on children, youth and their families. Monitoring the ECD agreement will test our collective policy development capacity and expertise in our efforts to participate actively with federal, provincial, and territorial governments. Monitoring the health and well-being of Canada's children in the context of the ECD agreement cannot be done effectively without the voluntary sector taking a leadership role.

Questions to ask our politicians about monitoring the ECD

- What baselines are you using for services and programs? What's in and what's out?
- Would you consider working with other governments to standardize the baselines so that they will be more understandable and consistent across Canada?
- Are you planning to make additional investments at the provincial/territorial level so we move closer to a "basket" of services at the community level rather than a "menu"?
- How can we work with you to develop indicators for children's health and well-being that help us better deliver services and programs?
- What sustainable mechanisms would you consider so that we can work with you to monitor "how well we're doing for our children"?
- Are you setting aside new resources for research and data collection?

Members of the National Children's Alliance

Adoption Council of Canada
Big Brothers and Sisters of Canada
Canadian Association for Community Living
Canadian Association of Family Resource Programs
Canadian Association for Health, Physical Education, Recreation and Dance
Canadian Association of Social Workers
Canadian Child Care Federation
Canadian Coalition for the Rights of Children
Canadian Council on Social Development

Canadian Institute of Child Health
Canadian Living Foundation
Canadian Mental Health Association
Canadian Nurses Association
Canadian Parents for French
Canadian Parks & Recreation Association
Canadian Public Health Association
Canadian School Boards Association
Canadian Teachers' Federation
Child Care Advocacy Association of Canada.
Child Welfare League of Canada
Children's Aid Society
Family Service Canada
Fédération des communautés francophones et acadienne du Canada
Foundation for Active Healthy Kids
Frontier College
Learning Disabilities Association of Canada
National Anti-Poverty Organization
National Voluntary Organizations
National Youth In Care Network
Pollution Probe
Scouts Canada
SOS Children's Villages Canada
UNICEF Canada
United Way of Canada / Centraide Canada
Vanier Institute of the Family
YMCA Canada
YWCA of Canada

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B-3

Tobacco Consumption During Pregnancy

Effects On The Psychosocial Development Of Young Children

by Karen Kidder

Prenatal tobacco exposure is recognized as a serious child health concern in Canada and internationally. This workshop focused on the on-going work of the Centre of Excellence for Early Childhood Development (CEECD) on tobacco as a determinant of child psychosocial health.

The CEECD seeks to identify and summarize the best scientific work on child psychosocial development. Importantly, talking about prenatal tobacco exposure and impacts on the psychosocial development of children represents a shift in the public dialogue. Public dialogue has tended to focus on prenatal tobacco exposure and pregnancy, and physical health outcomes. The CEECD hopes that a focus on psychosocial outcomes may stimulate different directions in research, and have new and unexpected impacts on services and policies.

The CEECD approaches this topic from three perspectives: development, services and policy. The development perspective examines what the research demonstrates about the impact of prenatal exposure to tobacco on the psychosocial development of the child. The services perspective investigates what the research tells us about services aimed to reduce prenatal exposure to tobacco. It also seeks research on the impact of these services on child psychosocial development. The policy perspective examines the effectiveness of policies that aim to reduce or eliminate prenatal tobacco exposures.

Tobacco and the Development Perspective

Psychosocial outcomes that have been associated with prenatal tobacco exposure in the current research include:

- ADHD
- cognitive differences
- neurodevelopmental differences
- psychiatric problems
- deviant/oppositional behaviours
- addictive behaviours
- conduct disorders

The CEECD has identified two key researchers in the field of prenatal tobacco exposure from the development perspective.

1. In the 1970s, Dr. Peter Fried, from Carleton University (Ottawa) started the acclaimed Ottawa Prenatal Prospective Study to examine the consequences of prenatal exposure to a number of socially used drugs, such as marijuana and tobacco. This study continues to follow the offspring born approximately 20 years ago. This is one of the longest prospective investigations of prenatal tobacco exposure. Published research from this study is widely recognized and cited.

2. Dr. David Fergusson, from Christchurch School of Medicine in New Zealand, has been the principal investigator and executive director of the Christchurch Health and Development Study, an internationally renowned longitudinal study of a birth cohort of 1,265 New Zealand children born in 1977. This cohort has been studied from birth to the age of 21 years. Dr. Fergusson has published extensively on the effects of prenatal smoking on child psychosocial development.

Tobacco and the Services Perspective

The CEECD is also researching prenatal tobacco exposure and child psychosocial development from the services perspective. This perspective focuses on research on services/programs directed at reducing or eliminating exposure to tobacco. It also looks at research linking these services/programs with improved psychosocial, emotional and behavioural outcomes. The CEECD is very interested in the "fit" between the child development research and current services and policies. We see this as an opportunity to raise awareness about any dissonance among them.

Tobacco and the Policy Perspective

The third perspective of the CEECD research is the policy perspective, which focuses on policy research directly or indirectly relating to prenatal tobacco exposure and child psychosocial development.

The scope of this research, as identified by the CEECD to date, includes:

- *A life cycle approach*: "It is essential to view the female life course from a broader perspective in order to consider the full range of policy options for reducing the infant mortality and morbidity caused by maternal substance abuse." John G. Frohna, Paula M. Lantz & Harold Pollack (1999)
- *Pediatric care settings approach*: "Further research is needed to devise more effective methods of using pediatric health care settings to influence adult smoking behaviours." Judith A. Groner, Karen Ahijevych, Lindsay K. Grossman & Leslie N. Rich (1998)
- *A child health centre-based promotion of a tobacco-free environment*: A Swedish case study. Elisabeth Arborelius, Sven Bremberg, A.C. Hallberg & A. Hakansson.

John Frohna and Harold Pollack, USA, Elisabeth Arborelius, Sweden and J.B. Lowe from Australia have been identified through the CEECD process as leading experts on policy as it relates to prenatal tobacco exposure and may be approached as authors or commentators.

Dr. Peter Fried's Presentation on Prenatal Exposure to Tobacco and Child Psychosocial Development

Dr. Fried presented on the impact of prenatal exposure on child psychosocial and cognitive development. As its principle investigator, he reported on the findings of the Ottawa Prenatal Prospective Study (OPPS), demonstrating the continuity of the findings as the children grow up.

Dr. Fried reported that, according to the OPPS, the children of the women who smoked cigarettes during pregnancy were negatively impacted in the area of auditory-based abilities and that this was especially pronounced in the verbal domain.

According to the OPPS, these impacts were apparent in the newborn and continued throughout childhood and adolescence. Dr. Fried cautioned that there were other variables that might explain the differences between the children of mothers who smoked during pregnancy and the children of mothers who did not. In particular, he mentioned the difficulties involved in determining the role of genetics. It is for this reason that the continuity of findings, from just after birth to early adulthood is so important. It strongly supports the idea that prenatal tobacco exposure at least contributes to the neurological problems identified in the study.

Findings by Child's Age

The OPPS researchers found that auditory responsiveness and habituation were diminished in the newborns of women who smoked during pregnancy. These newborns also demonstrated increased tremors and increased activity. There was a very clear dose-response relationship evident in the study.

At one year of age, the study found a significant diminution in the mental development index for the children of women who smoked during pregnancy. Tests revealed a clear impact on the verbal domain (examined through behaviour at this age).

At two years of age, the children of women who smoked during pregnancy demonstrated significant reduction in the mental development index and a significant negative impact on language tests. At age three, there was a remarkable dose-response relationship in intelligence. However, and importantly, the children of the women who smoked heavily during pregnancy still had IQs that were within the normal range. These children would not stand out at preschool or school. At four years of age the dose-response relationship was not evident, but the verbal domain really discriminated the children of the women who did not smoke during pregnancy from the children of the heavy smokers during pregnancy. Expressive language was more impacted than comprehension.

At five and six years of age the children were given a comprehensive neuropsychological battery – tests of intelligence, impulsivity and attention, fine and gross motor skills, memory and language among others. Parents were given questionnaires. School performance was examined. The results showed that the children of the women who smoked heavily during pregnancy tended to be somewhat inattentive and much more impulsive. The relationship between impulsivity and prenatal tobacco exposure has been found in other research as well. It is possible to make a strong case for other factors explaining this impulsivity. However, the fact that this impulsivity first expressed itself in the hospital neonate and continued throughout the childhood years increases confidence in the data. Continuity suggests that prenatal exposure to tobacco is at least a contributing factor to impulsivity.

At nine and twelve years of age information on the parents was obtained and then another battery of tests were performed. The results of the IQ tests demonstrated a clear dose-response relationship evident in the verbal domain as well as the full scale IQ. The study found that auditory processing, verbal IQ, the Peabody (expressive language) and fluency are all impacted. Various tests revealed that it was verbal processing that was underlying everything. It is not just sound discrimination.

Reading

Reading is an amazingly complex process. Two aspects of reading stand out: phonological processing (auditory memory – the association of sounds with letters) and orthographic (visual memory). Although overall reading was similar, the children of women who smoked during pregnancy showing reduced auditory processing when using a phonological approach and there was a clear dose-response relationship. This is consistent with previous findings. Interestingly, the children of women who smoked during pregnancy performed better with the orthographic approach than the children of non-smokers. Dr. Fried speculated that this may be some form of compensation for the auditory processing problems.

Conclusions

In Dr. Fried's research on prenatal tobacco exposure and child psychosocial development, there is continuity in the findings from birth through adolescence, with impacts in the area of auditory habituation and processing, auditory tasks, language, phonological aspects of reading, overall cognitive performance and impulsivity. This evidence comes from different avenues and is supported by animal research. Cause and effect is very difficult to establish and the prospective approach, where you can see continuity, is a very useful methodology. Although it is a quasi-experimental design (women cannot be randomly assigned to smoking or non-smoking groups), and has all the limitations associated with that, it is as close as we can get to a design that really is informative and that can deal with intervention issues.

Dr. Fried argued that telling mothers that they are more likely to have a baby with a low birth weight if they smoke during pregnancy is not a powerful enough message to change behaviour. He argued that parents need to know that low birth weight is the tip of the iceberg and that their child's neurological functioning may be impaired. At this point, we are not just talking about birth weight, but the child's future and the dreams that parents have for their children. Although not every child will be effected, the risk is real.

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B-4

The Negligence Research and Intervention Group

A joint university-community project to support and transform child protection practices

by Carl Lacharité and Louise Éthier

In the early 1990s, the provincial government in Quebec, through its Social Research Council (CQRS), adopted the goal of supporting joint projects involving academic researchers and professional practitioners working in the social, health and educational sectors; the Negligence Research and Intervention Group (GRIN) subsequently emerged as one of these joint projects. This paper attempts to describe what has taken place in this collaborative initiative involving researchers at *Université du Québec à Trois-Rivières* (UQTR) and the youth services centres in the Mauricie region and Central Quebec (CJMCQ). The paper also aims to highlight the main challenges of such a partnership and to outline the action strategies that have been used to meet these challenges.

Chronology of the UQTR/CJMCQ joint project

The various historical milestones in the UQTR/CJMCQ partnership are presented in Table 1 so as to bring out the factors that have affected respectively the university researchers and the managers and social practitioners in the community.

TABLE 1

Chronology of University-Community Collaboration

PERIOD	RESEARCHERS	COMMUNITY
1986-1992: Two solitudes	• Who are the children monitored by the DPJ? • Need to develop a theoretical model of the processes involving maltreated children • Practitioners are perceived as having little interest in research findings • Little relevant expertise vis-à-vis research	• Child-centred • A "homeopathic" interest in research: - research is superfluous - it is not productive in terms of the institution's mission and needs - researchers have a negative image; they take data and leave without giving anything back to the community
1990-1991: Together in the same business?	• Realize the existence and scope of child negligence and emergence of interest in the environment and family of maltreated children • What if we assessed the effectiveness of the services provided by the children's aid agencies? • What about a specific intervention program to deal with negligence?	• Managers discover that research can be used to assess both clients and practitioner practices • Practitioners interested in client assessment but not in having their own practices assessed • Program developed to meet their need for support and resources
1992-1993: Starting to live together	• Intervention program is designed by researchers and proposed to practitioners • Concern to standardize the experience • Realize how complicated child maltreatment cases can be and how extensive a range of skills practitioners need to manage such situations • Need to pool our know-how	• Community provides funding for demonstration projects (reducing caseload, paying support families) • Concern to make the experience more democratic (4 points of service) • Realize that researchers have clinical expertise • Need to pool our know-how
1994-1996: Conventional marriage	• CQRS recognition of research conducted in partnership (future directions = carrying out a research program and planning knowledge transfer activities) - The research program is "conceived" by researchers and disseminated to the practitioners • Knowledge transfer is perceived as a one-dimensional, unilateral process: - The researchers acquire new knowledge through the projects • This knowledge should be disseminated from the researchers to the practitioners - A "research" component is added to managerial duties • A few managers and practitioners participate on an active, ongoing basis, but their colleagues only take part to a limited extent (the "ghetto" effect) • Profound transformation of the institution's organizational structure: - movement of staff - territorial teams	
1997-2000: Striving for balance	• Introduction of a "partnership philosophy:" - partners are seen as equal and complementary - partners are involved at all stages of the research process - common spaces are created to foster regular contact and reciprocal support - the Negligence Interest Group is set up - "Summer Days" take place - Two community practitioners (liaison and development officers) are detached using research team funds - An award-funded researcher moves into the community - A management-level individual is detached on a full-time basis to the community	

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Since 2000: Expansion and looking outwards	• Other members (researchers and practitioners) are added to the research team; other partner communities are added • The research program is renewed along three lines: - acquire better knowledge of the psychological, social and economic risk factors associated with negligence and violence involving children - acquire better knowledge of the effects of situations of negligence and violence on children's emotional, social, cognitive and neuropsychological development - develop new prevention- and protection-oriented tools, and new professional and community practices in the area of child negligence - Active participation in VRQ and the Canadian Centre of Excellence in Child Protection and Welfare (CCEPBE in French)

Underlying issues and challenges in the joint university-community project

- "Research" culture vs. "services" culture:
  - Importance ascribed to innovation and external recognition ("publish or perish") vs. importance ascribed to problem-solving and internal recognition ("solve or perish")

- Research time vs. service time:
  - Take the time to think and then act systematically; conceive problems vs. obligation to find an immediate solution, even if only partial; we don't need to manufacture problems — "we've got them coming out of our ears!"

- Process of discovery and verification vs. process of action and accountability:
  - Formulate valid and well-founded generalizations on the basis of a number of individual cases vs. use generalizations to arrive at responsible action in individual cases.

Collaborative strategies

- Research team composition: Active participation of researchers, managers and social practitioners
- Create time and space to meet on a shared-cost basis: the GIN, "Summer Days," local "circles of expertise" (CLEs)
- Major structure-providing projects:
  - Model for intervening in cases of negligence: influence of professional responses to negligence in Quebec (Practices Development Program)
- Long-term follow-up of neglected children
- The VRQ project to promote Quebec-based research.

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Louise Éthier, PhD, psychology, has a particular interest in family characteristics related to neglect, stress, depression, perent/child attachment and family intervention.

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B-6

It's a Wake-Up Call! Suicide Prevention is Everybody's Business

Interdisciplinary Approaches to Mental Health for Children and Adolescents in Rural, Remote and Northern Canada

by Shirley Tagalik

Presenters: Caroline Anawak, Margaret Boone, Margaret Joyce, Bruce Minore, Shirley Tagalik, Josephine Tan, and John Vander Velde

Health service delivery in rural, remote and northern Canada involves its own unique issues that are different from those found in more urban, populated and southern parts of our country. These issues include:
- insufficient number of service providers
- lack of resources (e.g., access to specialized care)
- need to consult and collaborate with other sectors in the community (e.g., justice and school system, traditional healers, community leaders)
- duality of relationships between clients and service providers who may be related to them thus leading to potential problems of appropriate disclosure for health care
- lack of confidentiality regarding cases as events that occur in the community are usually known to others
- a sense of social isolation and lack of belonging as perceived by health service providers who originate from outside of the community.

1

All these unique challenges point to a need for an integrated system of service delivery that is inclusive and community-based, and that would allow individuals to get beyond the confines of their jobs or roles. Suicide prevention is an example in our talk; however, our message would be equally applicable to other service delivery issues.

The Story of Matthew

I am going to relate to you the story of Matthew. That is not his real name, but this is a real story, and one that will be all too familiar to those of you who work with the survivors of suicide. We pieced Matthew's story together from the accounts of a "critical incident" told to us by members of the multi-disciplinary human service team during interviews we did in a remote northern Ontario Cree community. The objective of this study was to gain a better understanding of the current practice of mental health care teams, *as teams*, in managing suicide related events.

At age 18, Matthew has had a troubled life. His father drowned when he was still young, leaving his mother to raise four young children. According to various reports, alcohol abuse and violence – including that on Matthew's part – has been a problem for the family.

The sequence of events I want to discuss occurred early in the fall, when Matthew was still 17. One of his teachers tells of a pattern of suicide ideation in his schoolwork: "He mentioned a couple of times that he wants to die, that he doesn't want to be here. He draws pictures of daggers and the words that go with it are 'kill' or 'death'. He's also [drew] a picture of a boy hanging – the message was [that] drugs are bad for you but just the picture of the boy hanging would be kind of like crying out."

Another teacher tells about a poem that Matthew wrote (and I quote): "... don't tell me you know what I'm going though when you have no idea what I'm going through. All you say is that you're going to help, but you can't help me." The teacher expressed surprise, since Matthew was a good student, although he allowed that he thought the boy was "using school to escape his problems, keeping himself busy and trying to get away [from his problems at home]." Once "those problems caught up with him and he no longer saw school as an escape," he started to skip school.

The Band Office sent Matthew to a conference on self-destructive behaviour. When he came back, the teacher reports that "he was more confrontational, more difficult to get along with and he made it a point to miss school more often." Eventually the principal sent a letter to Matthew deregistering him because of poor attendance. The letter angered Matthew since, as he pointed out, others who miss a lot of school are still allowed to attend. It also precipitated a series of violent events.

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The band constable was called to Matthew's home where the teenager, drunk and enraged, had cornered members of his family in the crawl space under the house. Matthew was arrested for disturbing the peace and taken to the lockup. While there, Matthew tried to hang himself repeatedly. "We had to cut him down about 8 times in a period of 4 hours. He was cutting his t-shirt and his shirt [to use] and his socks and shoelaces so we finally just said 'that's it' and we took his clothes off him." The police contacted the nurse, who attended to him in the lock-up and then put the wheels in motion to have Matthew sent south for a psychiatric assessment.

This did not occur before Matthew's next attempt, however. He was back at home a week later when the nurse received a call from the CHR. A family member had to cut Matthew down from a wooden hook that he had rigged to the ceiling of his room. They had confiscated everything lethal from his room and then called the CHR, the NAADAP worker and nurse for help. The NAADAP worker credits himself with calming Matthew by sitting him down, talking to him and counselling him spiritually. The nurse meanwhile arranged for an emergency evacuation and took his mother to the nursing station for respite care. It took 12 hours to arrange for Matthew to be medivaced out to the psychiatric hospital in Thunder Bay. There were problems in arranging to have a physician at the Zone Hospital in Sioux Lookout sign the Form 1, and for a police escort from Thunder Bay. Matthew survived his ordeal and is now back in the community.

Service Delivery Barriers

Researchers Bruce Minore and Margaret Boone asked the workshop participants to identify barriers that exist in service delivery situations and how these barriers can be addressed. The following points summarize the workshop discussion:

- It is important that every front-line worker has a full understanding of what everyone else does, the scope of the respective roles and how each role complements the others.
- We need to create opportunities for people to come together regularly so that we do not become isolated in our individual jobs. This would ensure that we develop common understandings and collaborative trust networks before a crisis arises.
- We are often hung-up on mandates and funding issues. We need to establish formal protocols to deal with this. We also need to establish protocols that come from within the community.
- There are also legislative requirements. There need to be attitudes and philosophies around requirements and reporting, and agreements as to how to operate in certain circumstances.
- It is also important to have common understandings of the values and ethics that underpin various situations.

- There are various procedures, perspectives and ways of operating that also need to be understood and agreed to.
- For any case, a lead person should be assigned to coordinate and manage.
- Debriefing a situation is important in that it allows the team to identify what worked well and what needs to be done differently.
- Establishing teams can be flexible. New team can form around new issues.
- Areas of confidentiality are a constant concern. What do we do to address this? There need to be clear policies and protocols around how we share information.
- The external role of different agencies needs to be considered because that often shapes what can be done at the community level.
- There is often a need for both formal and informal initiatives. It is important for interagency teams to have a focus on prevention and intervention and not just crisis response.

Suicide Prevention is Everyone's Business

Caroline Anawak from the Government of Nunavut's Department of Health and Social Services and Margaret Joyce of the same government's Department of Education became acquainted with each other by meeting at several different conferences. They realized that they shared concerns for the people of Nunavut. In her years travelling the north and speaking with elders, Caroline had begun to compile a list of Inuit values. These values were categorized into three themes: coping, working, and connecting / relating. These different themes of Inuit values were then made into posters and public service announcements, and translated into three languages.

Meanwhile Marg was creating a series of pictures to go with a list of values that her Department compiled. When completed, there were 34 different pictures, each with an associated value. The pictures were put on CD and distributed to schools and health centres in Nunavut.

While the values work was evolving, Marg and Caroline began an interdepartmental suicide prevention committee, which included many government departments, and several non-governmental organizations invested in the well-being of the people of Nunavut. This committee includes two elders and some community healers, and meets periodically to develop a detailed work plan to focus prevention efforts.

Following the Nunavut presentation, participants were asked to share their own stories about how these issues have been effectively addressed. A comment about the importance of researching the impact of these kinds of initiatives led to a question to the Centre of

Excellence team about whether there were plans to do this. A Crisis Management Team model in operation in Nunavut was described as well as a community helpers project and the Youthnet project. This project enables research to be done as part of every activity. There was discussion about programs that blend formal and informal support networks and how to integrate research, training, policy and best practices. The final comment from a participant was that it is very difficult to change policy that has become entrenched. Nunavut has a unique opportunity to start from scratch.

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B-7

Effects of Poverty on Children

Societal, Family and Community Pathways

by Sid Frankel

This presentation focused upon the societal, communal and familial factors that have been posited, in various theoretical formulations, to explain the inverse relationship between family income and a range of developmental outcomes. In addition, the causal pathways through which these factors are seen as operating were described and implications for program development and policy formulation discussed.

Ecological Developmental Perspective

The perspective taken is explicitly ecological, as proposed by Bronfenbrenner. This perspective places the child or adolescent in the middle of several concentric circles. The outermost circle, the exosystem, is composed of societal economic, structural and cultural factors that indirectly affect the child through their impacts on mesosystemic and microsystemic factors. The mesosystem, the middle circle includes communal social structural, economic and cultural factors that are mediated through the child's family. Community also appears at the microsystemic level, the innermost circle, which directly affects the child, as do familial culture, coping capacities and behavioural characteristics.

Theoretical Explanations

a. Exosystem

Two theoretical positions are considered at the exosystemic level. The first is Merton's anomie theory, which describes the effects of income poverty as adaptations to the gap between legitimate objectives and institutional norms for reaching them. These adaptations include innovation (acceptance of goals and rejection of means), ritualism (rejection of goals and acceptance of means), retreatism (rejection of goals and means), and rebellion (attempts to create new structure of goals and means). The second is Gans' labeling theory, which attributes the negative effects of income poverty to the operation of pejorative designations, which are seen as weapons in an ideological war against the poor. The operation of these labels occurs through socialization-based identification with them by poor children and youth, through limiting access to educational and other developmental opportunities and through social isolation and lack of access to informal resources.

b. Mesosystem

Mesosystem theories refer to the deleterious effects of the geographic concentration of poverty, of spatial juxtaposition of poor and non-poor communities, of community economic factors, and of community structural and cultural disorganization. Wilson has posited a collective socialization model which links economic transformation to increasing inner-city concentrations of joblessness, welfare dependency, single parent families and out-migration of working families, and, in turn, to limited occupational aspirations, poor school performance, low self-esteem, and lack of involvement in health promoting activities. Cloward and Ohlin have related negative effects to the unavailability or poor quality of developmental institutions in poor communities. Crane has developed a contagion theory which suggests epidemics of social problems in poor communities due to increased primary risk and increased secondary risk related to susceptibility to peer influence.

Leventhal and his colleagues have posited a social comparison theory related to an increased sense of relative deprivation when poor and well-off communities are geographically proximate or when pockets of poor families live in better-off communities. Ogbu has articulated a cultural conflict model that suggests that culturally based folk theories that support non-productive coping responses develop among minority culture youth due to a blocked academic and occupational opportunity structure.

Haveman and Wolfe have developed an economic choice model that explains poor developmental outcomes on the basis of the community opportunity structure and the balance of incentives for education and conventional employment versus illegal employment. Sampson posits a social disorganization theory that implicates the inability of social structures in poor communities to realize the common values of residents and maintain social control. This is associated with cultural disorganization that refers to the attenuation of societal cultural values because of community isolation and low levels of social capital.

c. Microsystem

In Becker's family investment theory child well being is determined by genetic inheritance, values and skills inherited through family culture, familial reputation and contacts and child-oriented expenditures. In turn, expenditures are determined by the level of family income, parental preferences, the number of children, the opportunity cost of child outcomes and taxes and benefits related to child-oriented investment. Poorer outcomes for poor children are seen as resulting from both a lower capacity of their families to invest, and possibly from fewer beneficial genetic, family cultural and positional endowments.

McCubbin and his colleagues have developed a family stress theory, which begins with the understanding that families living in poverty experience an inordinate number of both catastrophic and chronic stressors. Poor child outcomes relate to this and the lower quality of coping experienced by some poor families. The quality of coping is, in turn, related to the seriousness of the stressful event, how the family defines and appraises it, and the availability of family resources. These include material and instrumental resources, the individual capacities of family members, the quality of family relationships, the family's repertoire of coping strategies, and the quality of social support available to the family.

Lewis has developed a culture of poverty model that implicates the poor role models provided by some poor parents as a central factor in poor developmental outcomes for their children. The proposition is that a culture of poverty or an underclass has developed as a means of coping with structurally induced poverty and marginalization. Its values and sanctioned behaviours are inconsistent with healthy child outcomes. This culture is transmitted by parents and other poor community members to children. This approach has often been criticized as victim blaming.

Source of Effects

The ecological perspective suggests that the limited developmental outcomes experienced by some poor children can be explained by a number of source factors emanating from different levels in the social structure. There is also evidence that the interaction of these factors is important. For example, poor developmental outcomes may be prevented when deleterious societal factors are buffered by protective family and community factors.

Implications for Research

This perspective suggests that research should focus on the simultaneous assessment of the role of implicated factors at the familial, communal and societal levels, as well as interactions within and across systems levels. This will involve comparative designs across jurisdictions and the collection of a broad range of data from large samples of children and families. Research should focus on verification of available theory in order to advance our understanding.

Implications for Program Design and Policy Development

Even though all of the theoretical models and frameworks described above require further verification, they can play a useful role in specifying the assumptive logic of program design and policy development. Program and policy evaluations could then play an important role in the development of theory.

All of the models suggest implications for intervention. For example, Merton's anomie theory suggests that improvement of access to opportunity structures could lessen the gap between goals and legitimate means and obviate the need for unhealthy adaptations. This supports a focus on affirmative action and local economic development in poor neighborhoods. Anomie theory might also suggest providing support, through media and educational socialization, for cultural norms which value positive non-material goals.

Similarly, socialization might focus on lowering expectations, but if lowered too much they will cease to provide motivation. However, these latter two approaches might be criticized as normalizing inequity.

Merton suggests that innovation generally involves rejection of educational and occupational routes and adoption of criminal means to attain goals. Practice and policy might focus on supplying access to non-criminal and benign innovations in means, such as supporting micro-entrepreneurship by poor youth. Similarly, retreatism can be expressed as drug use and psychosis, and ameliorative programs might focus on more partial. and benign recreational retreat from goals and means. Retreatism, such as drug use, often results in secondary problems, such as criminal involvement to yield the income to purchase drugs and contacting infectious diseases through prostitution or sharing of needles. Minimally, a tertiary preventive strategy could attempt to limit the development of these secondary problems through, for example, needle exchange programs.

Merton notes that rebellion can lead to punishment, disappointment and exhaustion, as well as empowerment. Practice might focus on the development of opportunities for empowerment through legitimized and rewarding modes of rebellion.

Gans' labeling theory suggests action on public and professional education. This could involve the provision of public opportunities for identification with the human and social assets of poor communities. The media, the public and professionals could be provided with corrective information to counteract inaccurate pejorative labels. The could also be provided with information about the effects of labels, especially their contribution to self-fulfilling prophesies.

At the mesosystem level, Wilson's collective socialization model suggests such policy initiatives as housing and amenity development so that individuals attached to the labour market will move in to inner-city communities. Community economic development accompanied by supported training and job placement might also be necessary because of the absence of accessible capital and impaired self-esteem of inner-city youth. Opportunities for youth from poor inner-city communities to have significant contact with successful role models from similar economic and ethno-cultural groups would be useful in countering negative socialization.

Cloward and Ohlin's institutional resources model requires policy attention to improving the supply, quality and coordination of institutional services available to families and children in poor communities. The supportiveness of contact of institutional staff with poor families should also be improved, perhaps through enhancing the attitudes of extra-community socialization agents.

Crane's contagion theory would suggest the direction of efforts to educating poor youth to resist negative peer pressure as a primary preventive strategy. Where epidemics have occurred, the focus might be on generating norms for positive peer influence.

Ogbu's cultural conflict model suggests decreasing discrimination and improving access to opportunity structures. This should be combined with the attempt to introduce a norm of serious focus on education among poor minority youth. This could be done by using minority group members who have succeeded as role models.

Economic choice models suggest providing incentives for desirable choices, such as remaining in school. The costs of undesirable choices, such as criminal involvement, might also be raised, but this would depend on increasing the probability of detection. There would also be a necessity to ensure that information about desirable opportunity is transmitted to youth in poor communities, which are isolated from the mainstream.

Sampson's social disorganization theory suggests policy support for community development and capacity building, especially focused on geographically proximate family networks. There should also be support for community-based voluntary sector organizations, which can enhance the structural capacity of the community's social structure. Outreach by integrative organizations from outside the community might also be helpful.

At the microsystemic level, Becker's family investment theory suggests direct state investment in developmental services to supplement the limited investment capacity of poor families. It might also suggest enhancing taxation system incentives for poor parents to lower the opportunity costs of investing in their children's development and the provision of income-tested child-related transfers to families.

McCubbin's family stress theory would suggest several foci. One would involve attempting to limit the frequency of stressful life events through environmental change, such as crime prevention programs in poor communities. Another approach could focus on preventive skill building to improve family appraisal and coping capacities and to enhance internal family relationships. Finally, the organization of proximate social support for poor families with children would be recommended.

Lewis' culture of poverty model suggests two possible directions. One is structural change to eliminate extreme inequity, which leads to marginalization, isolation and the growth and maintenance of a culture of poverty. The other is resocialization of carriers of the culture of poverty into the values of conventional society.

References are available from Dr. Sid Frankel at frankels@ms.umanitoba.ca

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Linking Research to Policy and Practice for Children and Youth in Saskatchewan Schools

by Phyllis Fowler

with Bonnie Heilman, Louise Knowles, Mike LeClaire, Casey Murray and Del Williams

"If you want to captivate me, tell me a personal story. Share with me an experience that changed your life in some way. Let me see your eyes light up when you talk to me. Let me feel your words jump off the page when you write so passionately about this transition in your life. When you're finished giving me a glimpse into this amazing moment of change, show me the stuff you told me about: getting involved, doing something that means something, and accomplishing something awesome is something that I can do too." *Elicia Loiselle, Youth Staff*

Active student engagement has become the foundation for important change in Saskatoon schools, systems and community partners. A decade-long journey of research with our students has resulted in a significant shift in how our schools operate, how we can work more successfully with disengaged youth and how growing partnerships with our youth and within our community have enhanced our school climate and culture. We have built on the foundation of our community-based partner group, the Saskatoon Action Circle on Youth Sexuality. Their vision – young people and adults working together towards a holistic approach to sexuality – is grounded in the philosophy of helping adults learn how to be effective allies to young people – supporting youth leadership development, and promoting joint decision-making and youth leadership. This vision, combined with the philosophy of Integrated School Linked Services, has set the tone for building partnerships for improved services for young people in health, education and community services.

A. Our Partners in Practice

1. Integrated School-Linked Services (ISLS)

Nutana Collegiate Institute, Saskatoon

Service delivery agencies and, in particular, schools, have had to expand their role to meet an increasing array of student needs. Schools have no choice. They have to meet students' non-instructional needs, because effective teaching and learning are impossible when students are hungry, ill or needing emotional support.

Essential Principles of Integrated Services

1. holistic philosophy of education
2. decisions based on needs/strengths of the community being served
3. a shared vision created by working together
4. education system takes the lead
5. shared leadership, ownership and responsibility
6. first step is collaborative relationship-building: educational, business, community and government partnerships
7. process takes time and requires additional resources.

Objectives

- to remove the barriers of learning experienced by youth from challenging environments
- to create a collaborative culture among human service systems
- to effectively use existing community and provincial resources
- to enhance family and community participation
- to enable teachers to focus on teaching

Phyllis Fowler: "It is rare that one would find opposition to the notion that youth should have a voice – particularly in a school setting. After all, schools are all about youth. As a classroom teacher, I prided myself in engaging students in meaningful ways. However, both my colleagues and I were experiencing the frustration of empty desks on a daily basis. Understanding the reasons why many of our students were not achieving success became a priority as our school faced the threat of closure. Out of this crisis came an opportunity that has permanently changed the face of education within Saskatchewan.

It all began because we decided to search for answers by engaging our youth! Their responses to a student questionnaire provided us with a wealth of new information and understanding and served as the impetus for significant changes in our school philosophy and structure. We began to embrace new roles that forged partnerships with community, business and other government systems. We developed a strong collaborative team ready to tackle the opportunity and challenge of change. We know that there will always be light at the end of the tunnel if we focus our attention on what is best for students. We are challenged all the time to learn the "how" of meaningful youth involvement."

2. Saskatoon Action Circle on Youth Sexuality

The Action Circle is the current incarnation of long-term action by concerned individuals, agencies and institutions, towards youth sexual health in our community. People came to be part of the Action Circle in 1993 because of their personal experience or work experience and concerns about teenage pregnancy.

Out of a growing desire to support increased youth participation in the discussion about youth sexual health, the Action Circle hosted the first Youth Sexuality Conference in 1995. A number of students from each high school came together to discuss issues related to sexuality with their peers. Out of the conference grew the Youth Facilitator Training Project (YFT), which provided a small number of young people in four schools with facilitation skill development. Continued support to YFT project activities in the four schools, and a second conference in 1997, increased interest by other schools. Nutana Collegiate became home base for the project and the Action Circle/YFT became a member of the integrated school linked services team.

3. Youth Facilitator Training Project (YFT)

An initiative of the Saskatoon Action Circle on Youth Sexuality in partnership with Saskatoon Catholic and Public Schools, Nutana ISLS, Sask Ed and the Students Commission.

This initiative involves co-ordination & promotion of leadership development & facilitation skills with groups of young people. Students are committed to bringing awareness education into the classroom through facilitating a process to examine social issues that often have high impacts on school success – e.g., sexuality, addictions, peer pressure, dating and sexual orientation. The process brings some common understanding of the root causes for these issues and creates actions for positive proactive change – an empowerment education model. Young people actively take leadership roles that facilitate public education and youth advisement to others locally, systemically and provincially. This project's mandate is to create policy for young people to develop youth leadership skills through school curriculum.

4. National Partnership with The Students Commission

This partnership was established in 1999 through a cost sharing arrangement to create a youth staff position with an in-kind Students Commission office site at Nutana Collegiate. We have recently hired an additional fulltime youth staff at Nutana.

Del Williams: "This national partnership has grown and strengthened with our commitment to the work of the Centre of Excellence on Youth Engagement. High value has been placed in working together to integrate approaches and projects which fuse a national perspective to community action and to advise national initiatives based on our relationship with schools and community. Outcomes to this arrangement have proven successful and effective in that our current work compliments and integrates the agendas of each partner system on a regular basis."

5. YFT Project Partnership Group

This group meets quarterly to review/reflect progress and learning, to strategize on effective actions to challenge barriers and to collaborate steps for moving youth/adult engagement agenda forward.

Del Williams: "As I reflect on our growing engagement as a team, this partnership has become an invaluable inter-relationship of allies in various pockets of our system at different levels who are committed to the role of advocates to youth engagement... troubleshooters, mavericks, troublemakers, linking opportunities, sharing resources and most importantly...friends."

6. YFT Alumni Project

We bring young graduates of YFT back to their home school community in a peer mentorship role to emerging YFT groups.

Melissa Cotton: "I have been involved with YFT for over four years and it has opened some amazing doors for me. The longer you are involved with something, the more you realize what you can accomplish. Learning something new about yourself, good, bad or indifferent is a big part of youth engagement. Attending conferences, being involved with a group of young people, or just being asked what your opinion on something can be empowering to a young person... But you will never come up with a concrete formula for determining a level of engagement — it is a unique experience for everyone."

Jessi Gerard: "I started off here at Nutana with nothing to do. YFT seemed like fun, so I went along, and was rewarded for it... Thanks to the YFT, I can express my opinions more effectively, and I am not as afraid as I was in the past to make them known. As my friends know, I have a slight stutter, and I have been able to conquer that to some extent through my public oratory with the YFT."

7. CRU Westside Teen Wellness Centre

Saskatoon District Health, Saskatoon Public School Division is YFT's most recent partner in our public school systems development as the integrated services approach moves forward to three Saskatoon high schools on the west side. CRU shares a similar philosophy to the Action Circle/YFT, promoting sexual health through youth-driven activities. Sharing resources and experience means we don't have to reinvent the wheel.

Bonnie Heilman: "I was always concerned about things like violence, poverty and sexism. The difference for me now, is that I have a vehicle through which I can channel my negative feelings about social issues into positive action. This vehicle first came to me in the form of the CRU Teen Wellness Centre. When you go to this youth centre, your needs around engagement are met. Whether it is simply a healthy environment to hang out in, or a supportive home base from which you can conduct your community involvement and activism. For me, it was progressively both. It began as a place where I could hang out away from negative friends. Eventually, it nurtured my passion about social issues and gave me a chance to express them positively."

Louise Knowles: "It is challenging to support youth leadership outside of curriculum. The challenge for us, as adult support people, was to find the time to meet, schedule and make classroom presentations. We really felt committed to the project because of the positive results we noticed. Our teens were really showing leadership skills and I think that they truly believed that they were making a difference."

B. Linking Research to Practice

1. The Student Profile

Ron Berntson: "Arising from a general concern that their students were not being successful academically, Nutana Collegiate has been conducting questionnaire surveys of their students since 1990. What started as a simple exercise in data collection, has become an increasingly sophisticated attempt to understand the educational, social, and emotional underpinnings of our students. The questionnaire includes items on basic demographics, family structure, classroom climate, academic self-concept, depressive experiences, experiences of victimization, involvement with the health and justice systems, and addictive behaviours.

Analysis of this data has given us a deeper understanding of who our students are. In the last year, other schools in the city and province have been adopting similar instruments. In most cases, students, parents, community members, educators and other professionals have been involved in developing the questionnaire and interpreting the significance of the findings. Past questionnaires have led to structural changes in academic program delivery. Perhaps more significantly, they have also been used to communicate with community partners in the development of innovative onsite programs."

2. Action Circle/YFT participatory action research

- *Development Committee*: seeking funding to research approaches that ready adult allies to youth engagement.
- *Multidisciplinary Working Group*: a partnership with the University of Saskatchewan seeking funding to engage young people in researching champion teachers, in developing a best practice model of meaningful student-teacher partnerships, and in exploring ways that influence post-secondary education to teach empowering approaches to engaging youth.
- *Prevention Committee*: focus on engaging young student parents to create supportive networks, develop skills and to facilitate prevention awareness with youth in schools and community.

3. YFT Project

Young people from various networks recently critically reviewed the YFT project. The youth team compiled themes of desired outcomes into three areas: *diversity* of those involved; *increasing capacity* to grow & strengthen; and *adult engagement* readiness to support youth in leadership roles. Adult engagement is crucial to the project's ongoing progress. The project cannot aim to simply engage youth, but also train ourselves to engage adults. Youth need to find a way to teach adults the skills they need to take on roles as mentors and support people to engaged youth.

C. Linking Policy to Practice

1. Task Force on the Role of the School

Mike LeClaire: "The purpose... was to engage the entire Saskatchewan community representing such groups as families, educators, human service sectors, seniors, business and government in an informed dialogue on the role of schools. Of the 94 recommendations a belief emerged that we need to build a new kind of institution dedicated to the needs of children and youth. This new environment will be called School Plus, a vision for children and youth, building towards a new school, community and human service partnership in

Saskatchewan. Intertwined within this major initiative, is the concept that students themselves need to be full participants in the design of these changes proposed for any school. We made the following recommendations to make a partnership with students:

- That the participation and involvement of students become a cornerstone of both school policy and its application;
- That a variety of opportunities and venues be created in high school and middle years settings for soliciting the student voice, including conducting surveys and creating focus groups, and the canvassing of such opinion be regarded as a vital component of needs assessment and high school reform;
- That all Saskatchewan high schools embrace a school policy assessment cycle that includes canvassing student opinion on at least an annual basis, and reflection by staff on the feedback, with a view to modifying school policy and practice.

The importance of partnership formation with students would be not only in terms of their impact on quality of school programs and environment, but for their contribution to student character formation and development. Furthermore, we also recognized the impact student voice and involvement will have on the formation of social policy as this new journey for Saskatchewan citizens begins."

Del Williams: "Many of the young people in our networks want to become active participants in partnership with supportive adults in the critical thinking to solutions. While we, as society, are beginning to embrace the idea of youth voice in principle, our experience is that many adults are unclear about the concrete implementation of what youth engagement-youth participation really looks like or how it unfolds. For example, youth advisement is often considered a "one time" consultation missing the opportunity to develop an ongoing advisement relationship with students."

Rosanne Glass: "Youth engagement is the most hopeful and exciting movement I've experienced in awhile. YFT is one of several initiatives of the Action Circle. The Action Circle and related initiatives have informed the work of the Saskatchewan government in two key areas: Saskatchewan's Action Plan for Children and the work of Sakatchewan Education. Saskatchewan Education draws on the expertise of the Action Circle and its related initiatives for policy and program direction related to youth engagement and adult support."

Casey Murray: "Saskatchewan is a very exciting place to be right now if you have any involvement with the education system. What has sparked this effort to change the face of education is that we've finally realized that our schools aren't meeting the needs of all the students who attend them. By "all" I mean the high achiever, the at-risk and the middle-of-the-road students. More and more young people slip through the cracks, more drop out and more take little away from their school experience. We have been running very much the same education for most of this century.

As a youth coordinator working in a school on the leading edge of this movement, I have had many opportunities to provide input at provincial, regional and local levels. [I believe] we need to nurture students as whole beings not just as receptacles for academic knowledge. My involvement has shown me that meaningful youth engagement at the systemic level is very possible. Engagement is about learning together and from each other.

There is a real desire for more youth involvement and input into the process of changing the education system. Engaged youth can help to build ways to have ongoing, meaningful youth involvement and voice into internal organizational structures. I am hopeful that this will provide precedent in many government departments and other provinces. Meaningful youth involvement in the policy arena is key to having healthier communities, cities and countries."

D. Challenges

"There is a crack in everything...that's how the light gets in..." Leonard Cohen, "Anthem," *The Future*, 1992.

Making room for mistakes illuminates the path for healthy growth.
Del Williams: "I am suspicious of glossy descriptions of best practice models that do not get to the hard stuff — frustrations, mistakes, chaos, miscommunications, feeling overwhelmed, flying by the seat of our pants, behind the 8-ball. Operating an initiative outside of curriculum means that for young facilitators to engage with their peers in class or at conferences, to meet or to be trained, requires them to leave class themselves. To address social issues effectively requires focus to draw on leadership from youth expertise not typically engaged in their school community who often struggle academically. This is a dilemma as we risk conflict with school in order to do our work."

E. Moving forward

Adults can get youth interested. Then they want to know where they can be involved. One opportunity seems to lead to another, once they get their foot in the door. From there, engaged and empowered, they will reach out to other youth, giving them access to the resources they have worked to create. The ripple effect is their most important ally. If one youth is engaged, she will want her best friend to get involved, he will want his brother to participate, he will want his girlfriend to have a similar experience. This ripple will change the way youth walk through this world.

Phyllis Fowler is Program Director of Nutana Integrated School-Linked Services and System Development

Bonnie Heilman, Youth Staff, YFT/Students Commission

Louise Knowles, YFT Teacher Support, Holy Cross High School

Mike LeClaire, Provincial Consultant, ISLS, Sask Ed

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B-9

Early Childhood Development

Linking Research to Action for Aboriginal Children

by Richard Budgell

The Centres of Excellence for Children's Well-Being have given special consideration to the unique needs of Canada's Aboriginal children, their families and communities. Federal investments in Aboriginal early childhood development since 1995 have created a network of ECD child care and preschool sites serving Aboriginal children on and off-reserve. The question is, do we know what the impact is on Aboriginal children, and how much do we know about the circumstances of children in this marginalized group?

This workshop discussed:
- recent evaluation and research results relating to ECD and Aboriginal children;
- major gaps in current evaluation and research;
- whether we should develop a research agenda on preschool Aboriginal children.

Richard Budgell is the Manager of Aboriginal Head Start (Urban and Northern Communities), Health Canada

Whispered Gently Through Time: Recommendations for First Nations Quality Child Care

by Margo Greenwood

The unique needs of Canada's Aboriginal children, their families and communities, with regards to Early Childhood Development (ECD), guided a three year research and evaluation project sponsored by Child Care Visions. This submission describes and discusses *Whispered Gently Through Time: A National Study of First Nations Quality Childcare*, a project centred on early childhood education programs for Aboriginal children and communities.

The study sought:
- to determine First Nations definitions of quality child care;
- to explore First Nations jurisdiction and authority in child care;
- to examine the social, political and historical context of First Nations communities;
- to identify indicators of First Nations quality child care;
- to identify barriers and supports of existing child care legislation and policy.

Researchers involved in *Whispered Gently Through Time* interviewed 23 key informants, conducted six focus groups and undertook research in British Columbia, Saskatchewan and Ontario. Participants in the community-based research included First Nations policy analysts and academics.

Recommendations

Over fifty-four recommendations indicated an intense level of interest towards Aboriginal child care. The recommendations roughly follow three themes: programs and services; regulations; and First Nations jurisdiction and authority.

1. Programs and services

- Elders are encouraged to participate in children's programs, with appropriate protocols determined with the community, including monetary payment. Relevant and meaningful children's activities need to be developed, to incorporate skills that would be useful both in a school and community setting.
- Incorporate resources specifically earmarked for special needs, developmental difficulties and language and culture.
- Lobby provincial/territorial governments to include specific First Nations and cross cultural courses as mandatory in early childhood education programs.
- Recognize the experience and expertise found in Aboriginal communities and provide resources for the development of specific and locally-based culture and languages. Reinforce First Nations cultures and language by identifying each as a legitimate indicator of quality child care.
- Support national and regional First Nations child care agencies dedicated to quality child care services.
- Redefine eligibility for subsidized programs so that the special social, economic and political considerations of First Nations people are accounted for and are not limited to parents working or going to school.

2. Regulations

- Develop specific early childhood accreditation processes for community members and elders that are respectful of their life experiences and their desire to care for children.
- Create a new category entitled "community certified caregiver" as a ladder to formal early childhood education programs.

3. First Nations jurisdiction and authority

- Recognize First Nations child care as an Aboriginal right protected by Section 35 of the Constitution Act (1982), and enforceable by law as a legitimate right of First Nations government.
- Endorse and support community-based governance structures focusing on the needs of children and reinforcing healthy traditional child rearing practices.
- First Nations Child Care legislation should preserve and retain values, beliefs and traditions of the community.
- Make lawmaking authority of First Nations in child care flexible and adaptable to individual First Nations.

Suggestions

In addition to recommendations, participants made suggestions about future program development. These centred on the factors government programs should consider when they are intended for First Nations peoples.

- Governments need to include communities directly in their development.
- Timelines should allow communities to consult with their members in order to determine and define a child care program specific to their needs.
- Government should facilitate the development of a community statement with respect to the care of children.
- Government should incorporate flexible opportunities for communities to define and develop administration and governance structures.

Areas for future research

Participants agreed that research was needed on traditional and contemporary child rearing practices, in addition to research on First Nations values, beliefs and traditions. Family and community kinship systems, children's development from a First Nations perspective and best practices in service delivery were three other areas identified as needing future research. Finally, First Nations early childhood education programs, care in specialized settings, alternate processes for standards and regulations, and evaluation methods for First Nations' programs and individuals were other topics considered.

A comprehensive research foundation, extensive recommendations coupled with suggestions for future program development and future research, all combined to ensure *Whispered Gently Through Time: A National Study on First Nations Childcare* offers consideration of the unique needs of Canada's Aboriginal families, children and communities.

Aboriginal Head Start Impact Evaluation

by Debra Wright

1. Aboriginal Head Start (AHS) Program Impact Evaluation Needs

- Develop methodology and tools to measure impact of the AHS Program on Aboriginal children, families and communities.
- Identify or create tools which demonstrate the impacts that the program has on children, particularly in relation to the Aboriginal culture and language components of the program.

2. Project Description

In late fall of 2000, a working group of Aboriginal and non-Aboriginal individuals with varied child-development/Aboriginal research-related expertise, came together for five days to discuss potential tools for measuring program impacts on children. A range of existing and frequently used child-oriented tools were reviewed and discussed. While it was generally agreed that there were suitable existing tools related to school readiness etc., it would be necessary to develop custom measures in relation to the Aboriginal culture and language components of the program.

A small Tool Development Team (TDT) was established in early 2001 to design the specific evaluation methodology and to identify or design all of the related tools. This team arrived at an approach to identify program impact through a combination of the following key elements:

- Explore perception of change in children, parents and community as a whole through interviews and/or focus group sessions all stakeholders.
- AHS teachers use the Work Sampling System (WSS) and associated Developmental Checklist for recording children's progress with respect to language and literacy, mathematical thinking, physical development, personal and social development of AHS children.
- Child-oriented measures developed to record children's progress in acquiring vocabulary in an Aboriginal language and Aboriginal cultural knowledge.

- An environmental checklist to provide background information about the AHS site's cultural and language resources and to assist in analysis of other data.

The TDT is preparing to pilot the methodology and interview guides. The child-oriented measures developed by the TDT will be subjected to a validation process.

3. Conducting Research on Impacts in Aboriginal Communities

a. Include positive community involvement in the evaluation process.
  - We developed indicators of impact at the community level when the evaluation framework was prepared;
  - We conducted preliminary research with AHS sites to gain understanding of what they expose children to and/or teach with respect to Aboriginal culture and language;
  - We had the community identify local evaluators to carry out the evaluation pilot in that community;
  - We provided for community feedback about the piloting process.

b. Ensure that process is not too strenuous for the community
  - Evaluation fatigue is a serious concern in site selection. Sites that were recently involved in local and/or regional evaluations were not selected to participate in the pilot process.
  - We put as much of the workload as possible on local evaluators and the evaluation team, not on AHS site staff and we kept interviews as short as possible.
  - So as to not impose undue workloads, we chose to use only the parts of the system that would meet our most essential information needs. Early indications are that WSS is being embraced by those who have been piloting it, in part because it also meets a need of the sites.

c. Give something back to the community
  - The AHS evaluation is a national evaluation, not an assessment of individual site performance. We have tried to develop tools and methods that sites can incorporate into their own evaluations. WSS has day-to-day application and value to the sites should they chose to use it beyond the national evaluation.
  - By using and training local evaluators capacity may be developed or enhanced.

4. Implications for Change

WSS appears to being embraced by those AHS sites that have agreed to use it. The evaluation tools developed by the TDT may have implications for future teaching standards at the AHS sites.

5. Research Gaps

- Child-oriented measures that can be tied directly to the impacts of the AHS program.
- Statistical information that can be tied directly to the Aboriginal children in the community and in the AHS program.

Aboriginal Child Care and Evaluation

by Carol Rowan

My research has been in association and collaboration with national and regional Inuit organizations and territorial and federal government departments. It has been made possible with the essential input of community representatives and through my partnership with Ron Ryan of Consilium, a small Ottawa-based consulting firm.

What have we learned from conducting research in Aboriginal communities?

First and foremost, there is a core of dedicated early childhood educators striving to ensure the best possible outcomes for young children in their care. Second, responsible organizations and government departments share this desire to ensure the best possible outcomes for young children and their families and are seeking to understand the issues and to effect change in planning and policy to respond to the community based concerns.

In work conducted for the Nunavut AHRDA, holders identified key issues in a variety of areas these included: training, finances, community involvement, staff, resources, building, special needs, paper work, networking and support.

The two highest priority concerns are:
- *Training:* lack of training for early childhood educators and boards, as well as an absence of funding to pay replacement staff and lack of understanding about how to access training funding and programming.
- *Finances:* shortage of funds to pay staff, low salaries, funding unpredictable, confusion with variety of funding sources.

In the winter of 2001, the Inuit Tapirisat Kanatami (ITK) produced an *Inuit Early Childhood Issues Discussion Paper*. Here is an excerpt:

> *"Today the issues affecting Inuit children are broad reaching and insidious. Elders reported concerns about children living in violence and fear. They spoke about the breakdown of the traditional family structure, about language loss and the need to support and ensure that traditional Inuit lifestyle and knowledge are maintained."*

Key issues identified in the *Inuit Early Childhood Issues Discussion Paper*:

- Child and Health: poor nutrition, poor oral hygiene, high incidence of middle ear infections and acute anaemia, low quality of general health and overall well-being.
- Child and Community: housing shortage, poor quality housing, high cost housing, ECD training urgently needed, gaps in the availability of professional services, lack of interagency communication.
- Child and Education: High dropout rate, low attendance, low level of literacy, high level of special needs, comparatively low percentage of high school graduates.
- Child and Family: High incidence of teenage pregnancy and gambling, parents not spending time with children, communication problems within families.

Implications for changing practices

- Children's issues need to become politically important.
- Children's programming needs to be adequately funded.
- Funding and information must be community accessible and community directed.
- Responsible organizations and various government funding agencies must collaborate to ensure accessibility of funding and support and to strive for the best possible outcomes for young children.
- A plan for comprehensive community-based strategies must be collaboratively developed and appropriately funded.

Gaps between the programs and practice

The gaps with funding are related to the dispersal of funds into various federal, provincial and territorial departments, as well as among Inuit organizations. Each funding program has its own mechanism for access. As long as the funds are scattered here and there it will continue to be difficult for community child care centres to function well.

There is also a gap in training caused by the absence of a comprehensive training strategy and legislated requirement to hire trained workers.

The ITK's discussion paper stated that in order for children in Inuit communities to thrive:

- Communities must work together;
- Children must become the number one priority of the political leadership;
- Inuit regions must get together to plan for programs and policy to improve outcomes for children;
- The ITK has an important coordinating role to play;
- Federal provincial, municipal funding for children 0-6 should be pooled and a single entry, one-window approach developed;
- Access to qualified, experienced, reliable professional services must be secured;
- Action must be taken to ensure that Inuit culture, language and lifestyle thrives;
- Inuit in all regions should have equal access to children's funding.

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C-1

To Engage or Not to Engage....What's our Policy?

by Doug Ragan, Joah Lui and Josephine Tcheng

This interactive workshop in four parts was offered from a youth-driven perspective. It highlighted indicators of effective youth engagement in policy, youth engagement models and community mapping as a planning/engagement tool. Representatives from the Environmental Youth Alliance (EYA) and the Self Help Resource Association (SHRA) shared their research and research methods.

Part I Group Brainstorm

A facilitator recorded workshop participant answers to the question, "What Is Policy?" on a board. These answers stayed up throughout the workshop and are referred to as we journey toward understanding the different activities/perspectives involved in policy work.

Part II Mapping Exercise

Participants mapped their knowledge and experience of youth-&-citizen advised policy (making) in Canada.

a) Introduction to community mapping

Community mapping provides an inclusive and visual format for people to affirm and pool their experiences and knowledge about a topic. Maps do not have to have rigid boundaries and set points of reference. Community maps often are but do not always have to be about a physical place.

When mapping a theme such as policy (How does policy influence change in Canada?) we are mapping abstract ideas. We will start with a large blank (no lines please) piece of paper (at least 1 m x 1 m) and everyone gathers around to draw images or write phrases that describe ideas regarding the topic. The group brainstorming should not be linear. People should travel in a circular motion around the paper, jotting ideas down with no particular directional orientation.

Information can be project-specific or be in regard to universal themes. When all the ideas are down on paper, the facilitator will have people draw lines connecting different ideas. These lines indicate among other things: cause & effect, similar approaches, approaches that are parallel, people and processes that could benefit from being connected. A discussion follows in which the participants find common ground and new ways to collaborate and work together. The facilitator then asks the participants to share grand themes/ideas discovered during the mapping process and records them on a chart for all to see.

b. Small Group Mapping

The workshop participants are divided in small groups of 4-7 and given a large piece of paper. Group demographics should be diverse, representing the variety of perspectives and knowledge that may exist in the larger community. Alternatively, a group of people with a similar, unique perspective may also form (ie. youth), giving that community map the potential for greater analysis and depth on a particular subject.

Small groups map with 1 of these 2 questions in mind:

1. How do people affect policy in your community? (include youth if possible)
2. How do people/corporations/civil society affect governmental policy? (include youth if possible)

Notes for mapping:

- Whether you have direct experience or not working with youth in policy, participants attempt to map what they know or guess to be their involvement in policy.

- Different Levels of Policy
  Within this workshop, we explored different levels of policy: organizational, sectoral, municipal, regional, provincial, national and international. For the purposes of mapping, each group may limit their scope to one level or attempt to map their question more broadly by involving more than one level of policy development.

PART III Models and Indicators of Youth Engagement

In this part of the presentation, we shared different factors we have found helpful to understand what is good engagement and, following this, what is good policy engagement.

1. Linkage to power. Access to decision-makers. Networking Ability: Young people are encouraged, assisted, mentored in developing relationships with decision-makers such as bureaucrats or elected politicians.
2. Budget/Funding/Resources: Office space, computers, fax, staff, training, etc.
3. Strength of Youth Networks: Work with representatives of many youth organizations that serve a diversity of youth from different cultural & economic backgrounds. (Representation, collaboration, accountability)
4. Structure: Provides meaningful, necessary roles for young people. Cabinet, Roundtables, Special Committees or Councils with youth members, chairperson, staff, etc.
5. Decisions, planning, and work: Carried out by a majority of youth, with or without non-youth support.
6. Autonomy and legitimacy: Youth are able to speak for themselves as well as being responsible to a youth organization that they represent.
7. No thank you to We know what's best for you! A range of youth ages should be represented and the format/structure relevant to them. Especially if the activity is aimed toward a certain age grouping (ie. adolescent age youth), those youth (plural) should be involved in decision-making and consultation with the real intention of allowing their younger voices to be counsel.
8. Staff: If there is staff, some are youth.
9. Necessary supports are there for youth: Food, financial reimbursement for time, mentors, peer and other counselling support, positive and inclusive atmosphere, more than one youth is at the table, and adequate training for the task at hand (i.e., If the activity is to do policy work, then training about policy is critical).
10. Sustainability and Continuity: Systems set up so that information can be passed consistently from youth to youth. Important to have at least one young person (hopefully more) on staff to avoid loss of capacity through the revolving door. Are there multiple meetings, follow-up, and will the (same) youth be at the table at future consultations?
11. Longevity: Support for long-term vision means including younger youth, core funding and resource supports for the long-term (at least 2-5 years with the intention of moving towards self-sufficiency past the initial support period).
12. Training: Capacity building for individuals and the organization.
13. Other (as identified).

PART IV Youth in Policy

Workshop facilitators delivered an interesting, detailed triologue regarding effective approaches and examples of youth engagement. This was followed by questions and answers.

Joah Lui

Joah has spent the last 6 weeks researching effective models of youth engagement in policy and developing indicators with which to test for effective engagement. She has interviewed five young leaders (from civil sector i.e. not aligned with political parties or academic institutions) aged 16-27 about their past and current experiences in municipal, regional, provincial, sectoral, national and international levels of policy development. The research paper concludes with recommendations of youth engagement strategies developed in cooperation with various youth leaders in policy. The paper was made available to participants at the workshop.

An Excerpt from Joah's talk: "Advocacy, Activism & Policy"

"It seems that many people including activists, government bureaucrats, politicians, youth, etc. do not like to say these three words together. Yet, almost all the young people I know who are engaging in policy right now, self-define as activists and advocate many more things than just youth-inclusion in policy. Yes, policy work does have its rigamorale, its boring language, its excruciatingly slow and long timelines, its often non-transparent ties to where real decision-making is done, its in-fighting, its out-fighting, its representatives getting frustrated and dropping out, its burn-out, its what am I getting out of this? What I am trying to say is that policy making/changing is a complex game with many challenges for all of civil society. Young people have many opportunities through our Centres, our VSI, our Civic Youth Strategies, our regional health boards, our Foreign Policies, and our international UN conferences – to name only a few – to navigate policy paths both tried and new. In this learning, we can map what we find, look for overlaying common ground and lattice together new approaches for civil inclusion in social change."

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C-2

Working Towards a Framework on Middle Childhood and Adolescence

by Mary Johnston and Helen Leung

The workshop format combined a formal presentation of background information on middle childhood and adolescence with table group discussions. The latter allowed participants to engage in interactive discussions on the key elements that might be included in a strategy for this very important developmental period.

Workshop Objectives

1. to obtain input from workshop participants on how we can begin working together to build a framework on middle childhood and adolescence;
2. to share information and knowledge and to learn from one another on these issues; and
3. to have fun while doing it.

Workshop Results

The discussions revealed a consensus for the need for further work to be done in the area of middle childhood and adolescence. The evidence base is strong in some areas in this age group, particularly among teens, while information for middle childhood is currently lacking.

Much of the focus concentrated on the mechanisms and processes to develop this "framework". It was acknowledged that governments, as leaders, must work to ensure inclusiveness and diversity of partners around the table from the start. Young people must be engaged in any process directed towards improving their health and well-being, and this component should be established at the outset and maintained throughout the strategy.

A lot of discussion was around whether the approach should be a "framework", a "strategy" or based in a "charter" with commonly accepted mission and vision statements. Governments tend to develop theoretical frameworks that intellectualize the issues, detached from the community and the level of practice where activities take root. The impacts and the process of developing a "framework" prior to identifying the mechanisms that will be used to carry out the work was examined. Approaching the issue from the level of implementation might have greater success, especially for building consensus across the sectors on the issues.

The group overwhelmingly agreed that inter-sectoral collaboration is the key to bringing relevant stakeholders out of their silos. Cooperation across the areas of health, justice, education and social services allows change to occur in all areas that directly and indirectly impact on child and youth health. The Centres of Excellence for Children's Well-Being and the national inter-sectoral networks created by them have enormous potential to futher build consensus around the issues and contribute to the evidence base through research and knowledge development activities.

Who are We Talking About?

In recent years, there has been a concerted focus on early child development in Health Canada, throughout the Federal government and across Canada. This focus has come about largely as a result of building an evidence base indicating that if we, as a society, can help start children off on a positive developmental pathway, we can help promote their "healthy" or "optimal" development. Much of the work has focused on early brain development and the importance of a secure attachment in building pro-social skills and a pro-social approach to life.

Additionally, the "health sector" worldwide has been moving towards a population health approach to developing health policies and programs. Such an approach "focuses on the interrelated conditions and factors that influence the health of populations over the life course" (ACPH, 1997). Based on clear evidence of these inter-relationships, the primary focus has been on how to get Canadian children off to the best possible start in life.

Since the population health approach assesses health status and the influence of these factors across the life span, we need to ensure that related policies and programs are effective throughout the developmental continuum.

Development is a constant, life-long process of change, and from about age 6 to 18, it is not a uniform ladder with evenly spaced rungs. Rutter suggests it is a network of pathways with crossroads. Each of these crossroads requires a decision, which can change the direction of the final outcome. Each path can vary in many ways; steep, winding, smooth or rough.

In the middle years (about 6-12), children experience rapid social, intellectual, psychological and emotional changes, which contribute to their personal adjustment and social acceptance. The point at which and the success with which children make the transition to school and through school have a profound effect on the pathways they choose.

Adolescence, a relatively recent concept, begins roughly at the onset of puberty and ends with achieving adulthood. In nomadic and agricultural societies, children learned their adult roles as they grew up. At puberty, they earned their way into adult society by performing adult work. Often this transition was short and marked by a rite of passage. Once the transition was made, adult responsibilities were assumed. Since the Industrial Revolution, the period of adolescence has gradually been extended to include an additional period which we have come to know as "youth".

The period of youth incorporates adolescence but extends into the young adult years. Given the variable age and the considerable variation between national and provincial legal markers of adult status (e.g., voting age, obtaining a driver's license), as well as inexact transition points, adolescence cannot be considered a uniform or homogeneous life stage.

During adolescent years, a young person continues to acquire more abstract cognitive abilities, a more gender-based role, more social abilities, more independence, more skills and continues to shape their ethical system to guide their behaviour in society. They prepare for the transition to adult responsibilities.

Keeping this in mind, it is important to ensure that any conceptual model used to promote the healthy development of middle childhood and adolescence be comprehensive and holistic, not leaving out any key sectors or crucial concepts.

A population health approach:
- assesses health status and inequities over the population lifespan to analyse the determinants of health and interactions that influence health;
- uses evidenced-based decision-making to assess health, identify priorities and develop multiple strategies that focus on prevention rather than intervention;
- uses inter-sectoral collaboration / public involvement with demonstrated accountability.

Thus, there are a number of conceptual models that could be used to develop a framework on middle childhood and adolescence.

Example Frameworks

Child Development Working Group of the Advisory Committee on Population Health (ACPH)
This model has all the key components needed for a population health approach. It also adds

the concept of "youth involvement" as defined by the United Nations *Convention on the Rights of the Child* (CRC).

The CRC is an international legal treaty adopted in 1989, ratified by Canada in 1993, which outlines the inherent human rights of children and youth under 18. The articles within the CRC fall into four broad themes: survival, development, protection and participation. Participation refers to the relative capability a children and youth to be able to integrate and act on information and participate in making their own decisions about their lives, as appropriate to their stage of development.

The ACPH model does not differentiate the health determinants that directly influence health outcomes from those that function more indirectly. Nor does it take into account the settings in which young people live, learn, work and play, and how dynamics in these contextual environments influence their health and development.

Precede-Proceed Model of Health Promotion
The work of Kreuter and Green in the *Precede-Proceed Model of Health Promotion* fosters the inclusion of key sectors and stakeholders. It allows for application at various levels and can be used to frame a way of analyzing policies, programs and practices that directly and indirectly impact on the healthy development of young people.

Other conceptual models are possible and many are being used at different levels both nationally and internationally. Our task in Canada is to develop and achieve "buy in" for a conceptual framework that integrates all key stakeholders, including young people. A framework that is relevant and applied nationally, provincially and locally.

The Evidence Base

Key to the ACPH model is the evidence base concept and its use in decision-making. Decisions based on evidence are an underlying foundation to all policy, program and practice decisions made at different levels in a population health approach. Evidence comes in many forms. Considered together, the threads form a cycle for moving data from information to knowledge. Evidence also supports the ability to link research to informed program, policy and practice decisions.

Empirical evidence from monitoring and surveillance activities, such as the Canadian Incidence Study of Child Maltreatment and Neglect, administrative data from the Canadian Institute of Health Information databases, and population-based surveys such as the National Longitudinal Survey of Children and Youth, let us identify the incidence and prevalence of health-related issues or problems. Similarly, regular monitoring helps to show their magnitude for the targeted population.

Theoretical evidence from literature helps us identify important and relevant risk factors, and to identify opportunities for intervention. Qualitative evidence from research studies, stakeholder surveys, environmental scans and public opinion help define opportunities for influencing health related outcomes and provide evidence for where, when and how to intervene.

This evidence all requires careful expert analysis and synthesis to form a knowledge base for policies, programs and practice decisions. Collecting relevant data, use of data to produce information, and the analysis and synthesis of this data to produce new knowledge is a continuous cycle.

Once decisions have been taken and changes are being planned, an evaluation of their implementation and impact is necessary. Evaluation also uses many different lines of evidence. How were decisions planned and developed? Were they inclusive and participatory? Are they based on clear needs assessments? How were the resulting policies, programs or practices implemented? What evidence exists of their impact on target populations. This information fed back into the cycle results in continuous improvement.

As changes are integrated into the values, attitudes and beliefs of society as a whole, individual and societal actions shift. Continued surveillance fed back into the decision-making loop allow us to refine past decisions. A conceptual framework enables us to examine the state of the evidence base to develop a strategy that fosters healthy child and youth development. Without this framework, we risk leaving out sectors or stakeholders in the consultation process and/or missing critical evidence.

Working Towards a Framework

Change does not rest solely in the hands of one individual, organization or sector of society. Inter-sectoral, multi-disciplinary collaboration is important. Although identifying and bringing the right players to the table from the outset is a challenge, the benefits are overwhelming. Increased communication among groups enhances cooperation and collaboration. Partners build on one another's efforts instead of duplicating them. Shared responsibility and accountability build capacity for change in all areas that directly and indirectly impact health.

Currently, a number of mechanisms could be used help develop a framework on middle childhood and adolescence, building an evidence-base and consensus around issues.

The Centres of Excellence for Children's Well-Being have the potential to serve both needs. Each Centre is a national network of inter-sectoral partners who have come together to share information and knowledge, and to work towards improving specific aspects of child and youth health.

Many of the partnerships created through the Centres have paved the way for an infrastructure that could be used to support future work in this area. As well, four of the five Centres will be conducting research in areas directly related to middle childhood and adolescence, contributing to the evidence-base.

A great deal of expertise and knowledge already exists in the area of middle childhood and adolescence. By working together, sharing ideas and knowledge, we can support the development of a framework that meets the needs of children today, and that anticipates their needs tomorrow.

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C-3

The Impact of Prenatal/Perinatal Maternal Stress and Parental Leave on the Psychosocial Development of Young Children

About the Centre of Excellence for Early Childhood Development

by Ray Peters and Anne Maxwell

The Centre of Excellence for Early Childhood Development (CEECD) is one of the five Centres of Excellence for Children's Well-Being funded by Health Canada. The goals of the CEECD are:

- to identify and summarize the best scientific work on the social and emotional development of young children;
- to disseminate this knowledge to planners, providers and policy makers working in public and community services; and
- to identify areas that need additional research.

The work of the CEECD is guided by a Directing Counsel:
Richard E. Tremblay, CEECD Director, Université de Montréal
Emmett Francoeur, Université de Montréal
Sandra Griffin, Canadian Child Care Federation
Clyde Hertzman, University of British Columbia
Joanne Laverdure, Institut national du santé publique du Québec
John Leblanc, Dalhousie University
André Lebon, Centre de Psycho-Éducation du Québec
Ray deV. Peters, Queen's University

Sylvie Roy, Nation Atikamekw
Dawn Walker, Canadian Institute of Child Health
Alan Zeesman, Human Resources Development Canada.

The CEECD's commitment to excellence guides its processes for the identification of knowledge based on recent empirical research that meets the most rigorous standards.

The CEECD looks at research from three perspectives and thus has three Research Committees and coordination teams:

- Child Development Research Committee, chaired by Ron Barr, McGill University; coordinated by Karen Kidder and Budimka Oroz of the Canadian Institute of Child Health and Debbie Aylward of the Canadian Perinatal Partnership Program;
- Services Research Committee, chaired by Ray Peters, Queen's University; coordinated by Anne Maxwell and Tammy Martin of the Canadian Child Care Federation;
- Policy Research Committee, chaired by Alan Zeesman of the Applied Research Branch, Human Resources Development Canada.

The general coordinator is Claire Gascon Giard of the Université de Montréal.

The CEECD seeks to identify experts who are doing primary research in the field, who have been published in the best peer-reviewed journals during the last five years and who are recognized by their peers. The process of identification of these experts is based on an extensive literature review and a sociogram process.

Topics for review are identified by the Directing Counsel and by the Research Committees. Topics may be specific child development outcomes (e.g. school transition, school completion, aggression) or factors that may influence child outcomes (e.g. tobacco, low income, stress and parental leave).

The literature review is conducted by teams of coordinators, generators and validators. The coordinators prepare an initial literature review from all three perspectives. The primary database source is the International System of Information (ISI). This database is particularly useful because it includes the impact factor of the journal in which the article appeared and the number of times the article has been cited by others. Generators and validators are individuals currently, or very recently, immersed in the literature on the specific topic but not necessarily involved in primary research. The generators work with the coordinators during the development of the literature review. The validators read the literature review prepared by the coordinators and generators to assess its accuracy, completeness and appropriateness.

The sociogram provides a process for peer identification of experts. Each Research Committee identifies ten leading researchers based on the results of the literature review. These ten experts are each asked to identify ten people whom they consider to be the leading experts on the topic from the specific perspective.

Based on the results of the literature review and the sociogram, the Research Committees then identifies potential authors for syntheses on the topic. Other researchers are nominated as commentators on the synthesis papers. All papers are posted on the website of the CEECD in a multi-layer format that allows readers to delve as deeply as they wish on a topic. These papers will form a living encyclopaedia that will grow and develop during the five years of the mandate of the CEECD. The information will also be disseminated through the Centre's bulletins and through presentations at conferences and academic meetings. Also being developed for the website is a directory of Canadian researchers currently funded by the Canadian Institutes of Health Research, the Natural Sciences and Humanities Research Council and the Social Science and Humanities Research Council.

Today's main presentation focuses on stress and parental leave, and their impact on child development. If we looked at the research on this topic from the three perspectives of the CEECD, we could frame the questions as follows:

- Child Development – What does the research tell us about the effects of maternal stress during the prenatal and perinatal periods on development outcomes for young children?
- Services – How do parental leave programs affect development outcomes for young children?
- Policy – What parental leave policies have proven to be effective for positive child development outcomes?

The Impact of Prenatal/Perinatal Maternal Stress and Parental Leave on the Psychosocial Development of Young Children

by Donna Lero

This presentation will give you a bird's eye view of prenatal and postnatal stress and other kinds of stresses that parents are experiencing. We will look at parental leave policies and benefits policies as one approach to helping parents balance work and family, and hopefully provide a much stronger basis for early child development.

When I looked at the literature for material on prenatal stress, there was very little. There was a lot of animal research, but it's obvious that it would be unethical and irresponsible to subject people to stress for the purpose of studying how stress impacts a developing child. So what we have are animal studies and studies of naturally occurring experiments of parents who have a child with a disability or a brain injury, and we go back and see if there is something that can account for this. Unusual events like September 11th that appear out of the blue will no doubt result in many dissertations on impacts on children and on families over the next few years.

But I was surprised how little there actually is and I was even more surprised and disappointed to find how little research there is on parental leave and its impacts on children.

It's inappropriate to talk about stress as some kind of isolated thing that happens in a dramatic way to a few people on rare occasions. We do think of stress like that, but for most of us, the frame we live in is one of work-life conflict and increasing daily stress. That is the context in which I will discuss stress.

A number of studies have been done, very recent studies that show that work-life conflict and parenting challenges are a critical context. Last month, Linda Duxbury released a major report called *Work-Life Balance in the New Millennium: Where Are We? Where do We Need to Go?* through the Canadian Policy Research Networks.

Linda Duxbury and Chris Higgins have been doing research on work-life conflict, work-family issues for about 15 years now. Recently they have compared data collected early in the 1990s with data collected in 2001. The Conference Board of Canada has also been able to look at data twice in the 1990s. These studies provide us with detailed information about work-life conflict, role overload, work stress, depression in the workplace, etc.

These studies and others tell us that work-family conflict is on the rise. You can find much of this information free in the *Work-Life Compendium 2001: 150 Canadian Statistics on Work, Family and Well-Being* available from the Centre for Families, Work and Well-Being: www.worklifecanada.ca.

Duxbury's research includes a very large sample and has honed in on the nature of what is causing the increase in work-family conflict. She has looked at issues such as hours of work both at the office and at home. The blurring of the boundaries between work and home is more permeable, which poses some challenges. There is research on work stress, perception of workload and lack of control. There is research as well on corresponding feelings of depressed mood, and perceived job stress.

Parents are particularly affected, and others who have dependent care responsibilities. That is not surprising because the components of work-family conflict include both how much we are trying to do at the same time, and interference between the work domain and the family or life domain. Sometimes work interferes with family and other times family interferes with work, but in both cases it's a conflict.

People with dependent care responsibilities also have increased work-life stress, but parents of young children are off the charts on all these things. Their levels of work-family stress are higher than any of the other groups. Mothers' work-family stress is higher than fathers', a consistent finding for 15 years.

Fathers' work stress is starting to approach the level that mothers have had for a number of years. Part of this is because mothers continue to have the primary responsibility for care giving, for arranging household tasks, for monitoring that they are getting done, for planning ahead and thinking and scaffolding and so on.

Duxbury found that between 1991 and 2001 we are working longer hours. We now have a significant proportion of people who regularly work over 50 hours and some over 60 hours, plus our average number of work hours has increased. It has become harder and harder for people to answer the question: How many hours did you work last week? What do I count?

So what gets counted as work increasingly is a challenge. We take work home, we email, we have cellphones and pagers and fax machines that tie us more to work so that even off-hours, off-days and vacations may have work attached.

We have increased high-role overload. It's epidemic now. Various studies show that 45 per cent of workers say they experience high-role overload. In any medical circumstance, that would be beyond an epidemic. That's a very, very high increased level of family conflict.

The amount time in family activities has declined. What we do with children has also changed. When we work full time, the time that we spend with children tends to be more instrumental like going shopping or doing a household task, or truly leisure, but the things that are dropping out are the "being together" kinds of things.

Recreation is starting to drop and leisure time tends to include running – getting somewhere on time. So even "down time" has elements of stress in it.

Depressed mood is reaching epidemic proportions. The biggest loss to companies for absenteeism is due to stress and tension. The number of people on disability leave is very high. There is less job security. When people are insecure about their jobs and feel that there isn't that sense of a contract, no matter how hard they are working, that adds stress.

So although I came here to talk about prenatal stress and leave, it's very important that we remember stress is part of what many of us deal with on a daily basis.

Research indicates that there is growing awareness that we need to invest in children and support parents, and that work-family conflict is something that must be addressed. This awareness, however, is generally not coupled with consistent policy and program development. One bright spot is the change in policy and parental leave. It is seen as an advance in child development and parenting area, but we still have a long way to go in terms of early child development, child care programs and other areas that just seem to be taking forever.

Prenatal Stress

The research on prenatal stress is primarily scientific and medical. Some is psychologically oriented as well but stress is a difficult concept to define. If you go to the literature on prenatal development, you would find the literature on prenatal stress is about the fifth item down after infectious diseases, tobacco, alcohol and malnutrition.

It's difficult to say how many people actually experience prenatal stress to a major degree since that's not something most of us go around and count or think about and yet there are people who retrospectively will ask you to think about what major stresses you experience during pregnancy and when. For example, there may be a link between autism and major stress between the 24th and 28th week of pregnancy.

It's very difficult to form a causal connection between a retrospective account, but there is no question that stresses involve both biological responses and psychological responses.

The hormones involved in stress include the stress hormone or cortisol but during pregnancy many different hormones are affected. They include testosterone, adrenal and pituitary gland hormones, etc. With severe stress, a cascade of chemical events occurs. A major stress reaction it is a very significant event; your heartbeat goes up, you break into a sweat.

So a pregnant woman who experiences this kind of major biological cascade, you can imagine that this will impact on the developing fetus as well.

The animal research suggests it will have the following kinds of impacts: the developing brain system, the number of cells being developed, the synaptic connections, the number of synapses. In the second trimester, in the period of sexual differentiation, if rats have a major stress at that point, you get either all males or all females in the litter. This may suggest that aggression and sex typing is somehow influenced by the timing of potential prenatal stresses even in humans.

Most commonly suggested is the idea that if there is a physical impact on development, it will be prematurity and low-birth weight that we see. One researcher suggested that isolating stress is interesting because when you are stressed, most of us don't eat properly. Some of us eat a lot, but often nutrition falls off, exercise falls off, etc.

Mothers who experience more stress during pregnancy may have babies who have a more difficult temperament at birth. It's difficult to measure because having a baby with a difficult temperament is likely to cause stress. So is it a maternal perception, or was there actually more stress during the pregnancy?

The psychological responses that are part of stress affect our behaviour and our relationships with others. If a mother is highly stressed, her relationship with and feelings about her baby and others may be affected.

The component that correlates highest with prenatal stress for women is marital satisfaction. Fathers are different. The relationship does not seem to be the key stressor during the pregnancy. The stress for men comes from the anticipation of fatherhood if they haven't had a good role model or if they are nervous about being fathers, or if they don't know very much and feel overwhelmed. Also, pregnancy is one time when domestic violence is heightened. So the quality of the relationship and potential or real violence is a major source of stress.

To recap, stress can impact on prenatal development with prematurity and low-birth weight, subtle neurological and neurochemical effects, and possibly reactivity and temperament.

Postnatal Stress

The best predictor of stress for mothers in the postnatal period is the amount of stress they said they experienced in pregnancy. Thus, perhaps we should not think about these as separate components of life.

One of the biggest challenges during the postnatal period is postpartum depression. This has critical impacts on the quality of parenting afterwards.

The research suggests that postpartum depression is quite common, beyond the baby blues of the first week kind of experience that many women have. As many as 15 to 25 per cent of women have a significant postpartum depression. Much of the time it is not diagnosed. It does not necessarily manifest in the first week or two. It could start at the third or fourth month, and may continue for a lengthy period of time.

Doctors need to get better at diagnosing postpartum depression. It is particularly important because postpartum depression is a major stress on the relationship of new parents and on the capacity to parent well.

At the time when a baby needs you to be responsive, picking up on cue, establishing the kind of context in which they can develop self-regulation, a mother who is tuned out and non-responsive is creating stress.

Parenting challenges include not only the new child, but siblings as well. We know that at least half of births are to someone who has another child at home. There are additional challenges if there is a child with special needs or health problems at home. A new baby is more than a dyad.

Social support is critical in the postnatal period for mothers and fathers. Parents easily feel overwhelmed when they don't know what to do. And social support needs to be appropriate to culture and language to pick up on the needs that are important.

The impacts on children during both the prenatal and the postnatal periods are indirect. It is relationships and the quality of parenting. If children need responsive, stimulating care from a parent who herself is supported, then when that is not there, it's pretty telling.

Parental leave and benefits

Maternity and parental leave policies have been around in Canada since the 1970s, but we can trace the first maternity leave policy to the 1880s in Germany. Bismark was concerned about rising social unrest, about the fragility of the new German state, about fertility and about the next generation of children. He developed a policy of health insurance that included paid sick leave and maternity leave. France soon followed suit.

The major goal of the maternity leave that developed throughout the 20th century was maternal and child health. The first maternity leave policies were compulsory, to protect the health and well-being of the mother and child.

Now, we have far more extensive policies: income replacement; opportunity for flexible and lengthy leave. The impetus for public policies on maternity and parental leave is partly concern with health of the mother and newborn, but also concerns with increasing fertility and with labour market purposes. Job-protected leave protects women's attachment to the labour force.

There have been major changes in Canadian parental leave and benefits that took effect December 31, 2000. One of the driving forces has been the international movement to have better policies that protect workers' rights. There are some interesting articles that compare how Canada compares to other countries. Since Canada extended maternity and parental leave, we have moved from about the middle to a more progressive place.

For a while, Australia has given one year of parental leave but it's unpaid. Denmark gives 28 weeks (including maternity leave) at 60 per cent of pay. France gives 16 weeks maternity for the first two children and more time for subsequent and multiple births, with 100 per cent wages. Germany gives 14 weeks of maternity at 100 per cent and up to three years of parental childbearing leave at a flat rate that is income tested. European countries in the last few years have extended parental leave, and often with more flexibility than in Canada.

The U.S. is not a progressive example, with no federal maternity parental leave at all until 1993. Before that time, some states provided some maternity leave coverage under the Pregnancy Disability Act. The Family and Medical Leave Act provides 12 weeks of unpaid leave for maternity, adoption, a sick family member or an older dependent. It's more flexible in purpose, but it is unpaid and exempts companies with less than 50 employees.

Some of the U.S research results on maternity and parental leave are quite frightening: mothers coming back to work after just a week or two because they cannot afford to take more time off; some people go on welfare in order to stay home with a newborn.

Much of the research literature that we read about children and families is American. The Canadian context is different. You need to be country specific when you look at this issue.

Structure and coverage are important. In Canada, to be eligible for maternity and parental benefits, you now have to have worked 600 hours in the past year. However, there are groups then who are excluded for more reasons than not qualifying by hours worked. Self-employed individuals, a growing percentage of our workforce, are excluded. In Alberta, you must have worked for the same employer to be eligible for leave. So even if you have the 600 hours, if you don't meet the eligibility requirement, theoretically you may be eligible for the benefit but not necessarily for job-protected leave.

Generosity and flexibility in structure are important. Our structure for maternity and parental leave is that primarily it is around the time of a birth or adoption. So if you have a child and your child is injured or ill or disabled, you cannot use maternity or parental leave for that purpose. You cannot use it if you have an ill family member.

Some other countries have longer, more flexible options. Sweden, for example, combines the notion of banking parental hours that can be applied for part-time work up until the time your child is five.

One determinant of the length of leave taken is policy. Income also determines how long a maternity or parental leave will last. Coming back to work earlier may be that you cannot afford to take much leave, or because you have career goals. Attitudes are also critical; your employer's support or pressure for you to come back early. Another factor is the cost of child care, especially for more than one child. However, statistics show that the bulk of people come back to work after six months, which is exactly EI policy. Thus policy impacts parental leave.

The effects on children stem from the length of leave, the characteristics of employment and child care. The research on the impacts of parental leave on children does not tend to include much beyond the length of leave.

So to look at the longer term impacts on children's emotional and social development, cognitive and language development, academic achievement etc., based on parental leave and return to work, we need to understand the nature of the work you are returning to. And we are back work-family balance.

Child care is also critical. You can't evaluate the impacts of parental leave as if it has nothing to do with child care. Infant care is very expensive and is not widely available. Difficulty finding and maintaining good quality, reliable, affordable care is part of the equation on the impacts of parental leave policies.

Good news about extended parental leave relates to two specific things. Having longer leave results in women breastfeeding longer. Women tend to stop breastfeeding the month they go back to work, if they haven't already stopped. So breastfeeding is likely to be extended with the longer leave. As well, infant mortality might be reduced slightly.

The research that claims that longer time at home is more beneficial to children in terms of vocabulary development and school achievement is quite suspect. For example, the quality of child care is not factored in.

Some recent research suggests that the critical factor is not whether you are at home or working full or part time, but the quality of what you are doing: flexibility and control and support at work, or the quality of being at home, what you are doing with your baby while you are on leave or as a parent. In a new HRDC research project, we are looking at things like participation in family resource programs, in parenting programs, in the library, and with other young women in the community.

So while we started with the mandate of looking at the impacts of leave as a policy, I suggest that the real question is what is the quality of family life? What is the quality of work-life and how do policies impact on parents and parenting as mediators of children's development.

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C-5

Eating Right

Challenges and Issues Facing Children Living in Canada's Rural, Remote and Northern Communities

by Mary L. Courage, Patricia Canning and Lynn Frizzell

The National Research Coordinating Committee of the Centre of Excellence for Children and Adolescents with Special Needs has identified issues relating to nutrition, health and development as "special needs" for many Canadian children and families, especially those living in rural, remote and northern regions. Many of these regions are unique culturally, geographically and demographically, which creates challenges for promoting and attaining a healthy life style. This has been officially recognized in Newfoundland and Labrador where policies to address many of these challenges are being developed.

To address these issues with the agencies and individuals in the communities most concerned with them, we sought and received partnerships, collaborations and input from the Government of Newfoundland and Labrador, Memorial University, the Kids Eat Smart Foundation, the Avalon Consolidated School Board and Mount St. Vincent University in Nova Scotia. Together we identified a series of projects to address over the first five years of the Centre's operation. These projects include: infant low birth weight; the increasing trend in childhood obesity; the challenges facing school meal programs; and the impact of programs aiming to enhance the nutrition and well-being of low income families.

Although nutritional adequacy is integrally related to several factors, we focus here on some of the challenges to obtaining a healthy diet in Canada. These are not unique to rural, remote and northern regions but may be exacerbated by isolation and pockets of low income. They include:

1. *Cost.* "Good" food costs more. This places a burden on low income families who have to spend proportionately more of their disposable income on food than do wealthier families.
2. *Time and convenience.* Time is at a premium for many parents who have dual responsibility for child care and food security. Convenience foods free up time, but these foods are often high in fat, salt and preservatives.
3. *Taste preference.* Many Canadians prefer foods that are high in fat, salt and sugar. With the advent of modern technology, heated homes and the automobile, we need less of these foods but eat more.
4. *Inadequate information.* Data from recent surveys from the National Institute of Nutrition and the National Population Health Survey indicate that many people report concern about good diet and its relationship to health and have modified their eating patterns accordingly. However, much of this occurs among older, better educated, higher income individuals. Importantly, many Canadians are confused and cynical about inconsistent information about nutrition in the media.

In rural, remote and northern regions, transportation costs make food prices high and the variety, availability and quality of many food items lowers. Many energy rich and nutritious country foods (e.g., marine mammals, caribou, fish, sea birds and their eggs) have been contaminated by industrial and military sources, both local and international (e.g., mercury, cadmium, PCBs). Consumption of these foods is associated with poor growth, lowered immune system, certain cancers and contaminated breast milk. It is most detrimental to children and fetuses because of their developmentally sensitive growth periods. Finally, many food programs are more difficult to establish and sustain in rural, remote and northern areas because of transportation costs, the erosion of community capacity and the ineffectiveness of models of delivery that were originally developed for urban centres.

For these reasons, many Canadians get inadequate nutrition. In infants and children, this has long been associated with low birth weight, anaemia, delayed psychomotor development and growth, chronic childhood illness, dental cavities, lethargy, diminished attention, poor school performance, and lifelong poor eating habits and food choices. Until recently, inadequate nutrition seemed synonymous with inadequate amounts of food. Increasingly, we see poorly nourished children who eat more than enough. The problem is too much and too much of the wrong kind of food.

The most prevalent nutrition-related health problem evident today is obesity. Obesity is on the rise in Canada in both adults and children. By the 1990s, 48% of Canadian adults were overweight. Children are more overweight and obese than ever before at ever-younger ages. The rates of obesity rose from 15% in 1973, to 24% in 1984, to 35% in the 1990s. We are also seeing significant increases in the prevalence of overweight in preschoolers. In 1989, 15% of preschoolers were overweight and 5% were obese; by 1998, 22-35% of children were overweight and 10-15% were obese.

Even more alarming are the increasing numbers of children who exhibit adverse physical effects of their poor eating habits, which can be greatly exacerbated by obesity. Numerous studies report the prevalence of risk factors for later health problems: high cholesterol, hypertension, and impaired glucose tolerance, even in young children. Autopsy studies in children have revealed the presence of the fatty streaks and fibrous plaque lesions that mark the beginning of heart disease. In overweight children, 60% have one of these risk factors and more than 20% have two or more risk factors.

Not only are children showing early signs of later diseases, but they are being diagnosed with diseases once called "diseases of adulthood," specifically, Type 2 Diabetes and high blood pressure. The average age of diagnosis for Type 2 Diabetes was once 40 years. The last decade has seen a tenfold increase in Type 2 Diabetes in children and adolescents, with children as young as five years diagnosed. High fat, low fibre diets and minimal physical activity are implicated, and obesity appears to be the single-most important factor. Similarly, children are being diagnosed with high blood pressure. One study reported 11% of preschoolers with high or borderline high blood pressure. Overweight children are again at an increased risk – two to three times greater than their leaner peers. The time to prevent obesity, and its co-morbidities, is in the preschool years, if not earlier.

The risk factors for childhood obesity include maternal obesity, low family income, poor eating habits, lack of physical activity and a lack of parental recognition of the child's obesity. Eating habits begin early, in the preschool years. Children as young as three years of age tend to prefer high fat foods if their parents are obese. Research has shown that very young children are not influenced by portion sizes and will eat only what they need, regardless of the amount of food they are given. However, by five years of age children will eat more than they crave when presented with larger portions. Since the behavioural antecedents for nutritional risk factors begin early, we need to do more to teach children, parents and educators about the importance of healthy lifestyle choices. We need to begin early and we need to support the ability of families to tackle the barriers to healthy choices.

Newfoundland has the distinction, albeit a dubious one, of leading the country in most of these nutrition-related health problems. Our research group is well placed to investigate these health trends and to evaluate programs aimed at reversing them. Our motivating concern is for the short- and long-term implications for children, and our work is well supported by eager community and government collaborators.

In collaboration with the Department of Human Resources and Employment (HRE), we are developing a project using data gathered through HRE's new Mother Baby Nutrition Supplement program (MBNS). This initiative is part of the government's contribution to the National Children's Agenda. The MBNS program enables participants to get information, to secure a referral to their local public health nurse and healthy baby club, and to apply for a monetary supplement. We propose to use application data to get a regional picture of the demographics of low and high birth weight in this province. Comparisons between MBNS program participants and non-participants permit some measure of the program's impact on healthy birth weights. We hope to follow participants and their families through the preschool years.

Our Trends in Preschool Children's Body Weights project utilizes the Preschool Health Check Database of the provincial Department of Health and Community Services. At age four, most children participate in the preschool health check offered by their local public health nurse. Assessment includes speech, language, hearing, vision, height and weight. This information will allow us to:

1. establish a current regional picture of preschooler's body weights;
2. determine the age at which overweight and obesity begin;
3. advise on the target age for preventative program planning;
4. establish a baseline for the evaluation of intervention and health promotion programs; and
5. track future trends.

Furthermore, because health records include birth weight, an investigation of a reported link between high birth weight and later obesity is proposed.

Our first priority is to design a survey of child participants. As well, we will survey school personnel and members of communities with school food programs. We will assess program impact on attendance, grades, disciplinary actions, school atmosphere, and on the level of volunteering in the school and in the greater community. Also underway is a study to determine best practices for rural, remote and northern communities, by examining programs operating successfully in communities with apparent low community capacity. Integral to this research is the use of the province's Community Indicators Project, which provides a means to quantify and rank community capacity.

These current projects recognize the existing significant barriers to good nutrition and the increase in nutrition-related diseases, especially in the young. We hope our results will have future impact on the health and well-being of children and families. We are encouraged by the efforts of government and non-governmental organizations at all levels.

Their continuing commitment to fund and support the research that directs program and policy decisions is essential to ensure further inroads are made against the barriers to nutritious eating.

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C-6

What Happened to Main Street?

Aboriginal Holistic Perspective on Well-Being

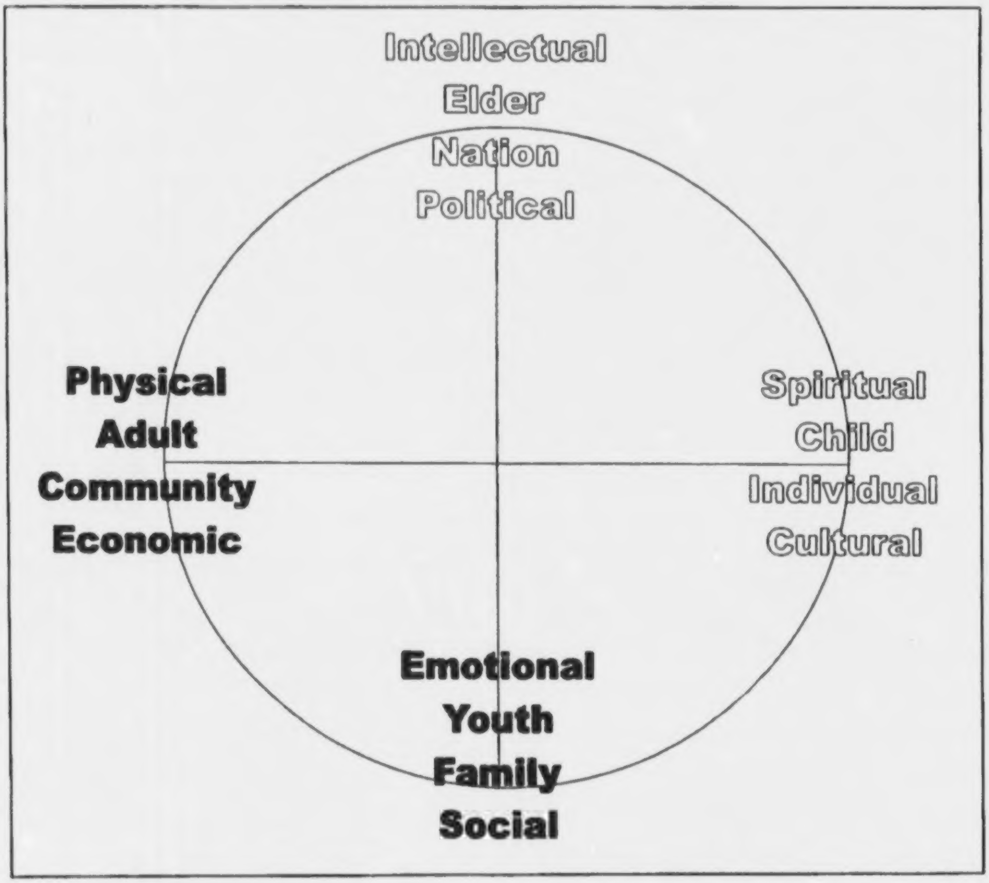
by Judith G. Bartlett

In asking What Happened to Main Street?, the Aboriginal community in Winnipeg provides an excellent example of a willing community. Over several decades, the Aboriginal community has collaborated extensively with other Winnipegers to reestablish the dignity and affluence of Main Street, a metamorphosis that is now clearly visible. The Thunderbird House, the Aboriginal Centre and the Manitoba Metis Federation offices are more than just buildings; they are a "breath of life" in an area of the city that many had thought lost. This presentation gives a brief overview of an Aboriginal philosophical approach that is increasingly an underlying principle in collaborative community approaches such as the one we used in Winnipeg.

The Aboriginal Health and Wellness Centre of Winnipeg developed a framework that can be used by anyone who wishes to explore holistically the context of their own existence, whether at a personal or systemic level. The rationale for development and the characteristics of the model demonstrate how we can work together toward a balanced and prosperous future.

I began "constructing" the framework in 1993, as a member of an Aboriginal group committed to working on our community's' request for a holistic, culturally-appropriate clinic. This process led me to explore the nature of holism and humanity. Dr. Scott Peck, author of *The Road Less Travelled* believes that humans' dramatic relative lack of instincts or inherited patterns of behaviour is what contributes most to our humanness.[1]

This, I believe, is "the great hope for humanity"; the vast potential for coming together for health and healing. More than any other form of life, humans have the ability to "consciously choose" how to respond to our fellow human beings and to all other life forms. For "the great hope" to transform from potential into reality, we need "will". It is with great optimism that I present the Medicine Wheel Life Promotion Framework© (MWLPF).


Intellectual
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Youth
Family
Social

Framework Rationale

The framework was not developed as an academic exercise, but as an intuitive tool to discover how we could facilitate the aspirations of our community. During early development, although many spoke of the concept of holism, there had been little defined in the area of health and wellness service delivery. Although we had conceptualized the "first" circle of the medicine wheel (spiritual, emotional, physical and intellectual), we did not yet understand how to translate this into the types of programs our community envisioned.

Initial work was to establish the principles upon which all development should proceed. We came to understand the need to clearly articulate our community's global concept of holism and translate this into user-friendly programs grounded in the cultural understanding of all who would use it.

We needed to both accommodate the extensive cultural diversity of our urban community – Cree, Ojibway and Metis to name a few – *and* build a sense of common vision. This framework also had to accommodate Aboriginal people's existence within a wide continuum of interactive preference with society, from traditional to contemporary.

We needed a non-directive framework since our community had long been directed by others visions and paradigms. We wanted to ensure there could be little potential for the tool to be used to indoctrinate. We could not repeat the status quo of providing standard "health promotion" programs that are in essence a form of social marketing intended to provide Aboriginal people with lifestyle training so they become replicas of the majority society. Our community *is* distinct and we had the right to retain this uniqueness.

The framework also had to serve as a tool for self-discovery and personal empowerment. For any type of healing to occur, individuals must first understand the context of their own existence, and then understand that there exist "choices" in life. Choice in interactive preference in all matters is essential in order to gain the confidence that one has the power to act upon such choices.

Earlier I used the term "constructing" the framework. This reflects the fact that the component circles of the MWLPF already existed in Aboriginal communities across Canada, sometimes singly and occasionally with two circles combined. To add to the first circle, I "selected" three more commonly being used. Understanding "health in its broadest context," I concluded that these four simple circles combined a basic minimum holistic picture of key elements of human existence that could make intuitive and common sense to ordinary Aboriginal citizens.

Framework Characteristics

The framework is based on the Aboriginal perception of the cyclic nature of life and death, and universal principles of sharing, caring, kindness, honesty, respect, trust and humility. The sixteen elements can be thought of as "determinants of life" framed in a simple picture that ensures the "whole" is addressed in a connected and integrated manner. No single element can be fully understood in isolation from others.

The meaning of health in many Aboriginal communities is the ability to attain balance. Using this medicine wheel, health is defined as attaining balance of the spiritual, emotional, physical and intellectual aspects of individuals, members of families, communities and nations within the context of their cultural, social, economic, and political environments. This tool is called a "life promotion" framework because it is about balancing the internal and external elements that influence life. It also reinforces the need to consider that a holistic approach includes factors beyond the health sector.

Each element has both individual and societal meanings and influences. The element "political", for example, might be considered broadly as being about one's ability to "have a voice," whether personal or societal. The framework also attends to the concept of reciprocal action; if one element is addressed there will be a reciprocal change in one or more other elements in another part of the circle.

Both simplicity and a concept I term "empty cells" are important. Simplicity helps those without higher education better understand, and prevents those "with" higher education from attempting to impose onto others what we have learned from our own journeys. The concept of "empty cells" is important because every individual can develop their personal meaning for each element.

Thus the framework can be a personal discovery tool, for recognizing and respecting one's personal cultural identity. This allows individuals (and groups) to overcome the destabilizing influences that prevent them from finding and understanding their historic sense of coherence.

Alternatively, the framework might be used in policy development. Extensive analyses of each element ensures that policy in any particular area would be clear on the implication of and affects on all elements. Using the same framework at both personal and political levels might increase the ability and willingness of the general public to be better informed about and participate in policy development and ensure its implementation.

Is the orientation of the elements important?

The circular format of the Medicine Wheel represents the never-ending circle of life and death, and a matrix offers an organized guide to analyze life factors and support balance. This is relevant regardless of educational attainment, sophistication level, professional discipline, sector or cultural group. The most basic level is defining the elements, but one can combine elements for further analysis such as reviewing what a group of elements symbolizes.

The third circle displays the levels through which we form interactive networks as individuals, families, communities and nations. Identifying strategies for action can follow this for program development. We can ensure that in all our interactions we support the individual in defining the elements for themselves, and in working on the eight broad areas of their life – personal nature, identity, life stage, relationships, networks, supports, environment and voice.

I call these Wellness Standards – those areas of a person's life to be explored as part of prevention or promotion within a program. For example, the Canadian Diabetes Association Clinical Guideline outlines many aspects about the physical body that must be addressed in order to provide optimum care to an individual who has diabetes. I propose that exploring and addressing the eight Wellness Standards is essential to achieving optimum management of diabetes and maintenance of well-being.

The elements of living spin rapidly about us in our everyday experience. It is difficult, at times, to determine where one element ends and another begins. This is true if one's identity has been confused by generations of colonization, and is equally true for anyone in today's rapid-paced society. The two-dimensional medicine wheel is a method to stop spinning elements such that one is better able to tease them apart, enhancing the ability to deal with individual elements.

Multidisciplinary Collaboration

The MWLPF is useful for inter-sectoral multidisciplinary collaboration because it helps to develop a common vision and context for action. The framework can be used for any concern, or to assess any strength or challenge. They simply sit in the centre of the circle and all elements are addressed to determine relationships and/or impacts.

It can also function across disciplines, professions and sectors to stimulate collaboration. The constituent sits in the centre of the circle and the multiple parties focus on this individual and his or her strengths or challenges rather than professional or mandated ways of dealing with them. A common language is particularly important if a family is involved with multiple agencies. Often the response to the multiple languages of the different disciplines in to simply ignore all of them.

Another important area and challenge, relative to collaborative efforts, is the relative absence of clear articulation of a "health promotion" and population health model that includes both agency (individual) and structure (society).Discussing the need to consider a thorough integration of agency and structure when choosing a new research methodology, Poland states:

> *"The adoption of a theoretical stance or conceptual framework that recognizes dualism would reinforce the rhetorical commitment of health promotion practitioners to integrating social and individual influences on health and human action and to identify the full extent of these systemic/structural factors."*[2]

This framework clearly combines the concepts of agency and structure into a single integrated picture whereby each element can be viewed on both an individual and societal basis. It encourages individuals to explore society's relative influence on personal circumstances and their sense of personal influence on society.

Why is the MWLPF useful in understanding and acceptance of uniqueness and diversity?

In order to become a willing community, we need to understand and accept both uniqueness and diversity. This framework facilitates equality between individuals and cultures through the symbolic "colours" of four directions. It signifies that all peoples play a necessary role in balancing the medicine wheel – or the world. Because there are "empty undefined cells," the framework can be used by any cultural group to define, in their own way, the meanings of the elements, thus allowing for extensive diversity of beliefs.

For example, culturally one might identify as Metis and choose to symbolize and practise spirituality through traditional ceremonies and fasting. Another may identify as a Cree First Nation and choose to symbolize and practise spirituality through religion and church. Both are valid. This approach facilitates respect for the individual's choice within their society.

Cultural identity and choice can function for all groups since we all have some personal and unique sense of spirituality. Individuals who identify as atheists or agnostics have made a statement about their spiritual position. The key is respecting each person's choice without trying to superimpose one's own identity onto another person. We all live the same elements every day of our lives, but we each live them uniquely.

Conclusion

The Medicine Wheel serves as a framework that takes an organised approach to understanding and integrating important elements of human existence. Health is defined as "balance" of all life elements. The framework is intended to support individuals and families (and potentially communities or nations) look at their existing strengths and challenges. In order to provide an environment for healthy living and prosperity, each element requires the development of personal (or group) meanings. An in-depth analysis and development in relation to every other element follows, whether for personal development or for policy development.

Achieving the maximum capacity of development and integration of elements, in a continuum from individual through the nation, enhances holistic well-being. I believe that the Medicine Wheel Life Promotion Framework can foster understanding, respect and interdependence as we journey forward in Winnipeg as a committed and willing community.

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C-7

The Challenges of Effective Youth Engagement in Research

by Stoney McCart

with Dan Breault, Lanny Jimenez, Bonnie Heilman, Eric Costen, Barb McIntosh, Mark Pancer, Linda Rose-Kraznor and Del Williams

Our experience as the core partners of the Centre of Excellence for Youth Engagement suggests that adults need to "experience" youth engagement in order to become effective practitioners and policy advocates of the concept and the practice. It was with this in mind that workshop participants were greeted by Bonnie Heilman (a youth presenter from Saskatoon). Wearing pyjamas, Bonnie handed participants consent forms, stating that they needed permission from their child before being able to speak about youth and adult engagement.

Questions began immediately: "What did the form mean?" "Weren't they (workshop presenters) confused?" "How could they possibly get the form signed?" "Did they really mean that their children had to sign." Bonnie replied coolly, if they couldn't get the form signed, then they still could participate in the workshop, but none of the information they supplied would be included in the research.

Dan Breault, another young presenter from Calgary, wearing a sarong, handed out different coloured pieces of paper, one each to each participant. He then asked the group why they do what they do (for a living). He directed them to write their answers on the paper and to post their answers on the wall in the front of the room.

Next Bonnie, Dan and Lanny Jimenez, another young presenter from Vancouver, greeted everyone in English, French and Spanish. Lanny took over the workshop in Spanish briefly telling everyone what would happen next.

After Lanny modeled a sample research interview, in Spanish no less, during which the adult participant was unable to understand many of the questions and her answers were short or non-existent, Dan conducted a sample focus group with the workshop participants.

First, however, he made himself more comfortable by removing his shirt, revealing a studded harness, an assortment of tattoos, and a pair of nipple rings. His first question for the group was: "'sup dawgs and chickenheads?" No one answered. Undeterred, Dan continued: "How you gonna kick it? You gonna spell that with an OG? You down with c-note?" Still, no response from the group, and people were becoming increasingly (and visibly) uncomfortable.

Stoney McCart reminded the participants of the name of the workshop and asked the group to identify some of the challenges presented so far. She asked the group to reflect on how they had been feeling during the past several minutes: "Frustrated", "resentful", "tense", "confused", "uncomfortable" were some of the answers. People admitted: "I was okay with the Spanish, that was sort of expected, but Dan, I wanted you to just speak in English." "I had no idea what you wanted, what was going on, what the purpose was." "The questionnaire didn't make sense." "How could I get a permission right now?" "I didn't expect that I'd have to participate; I wasn't prepared." "I didn't know what was coming next."

The remainder of the workshop was an effective dialogue covering challenges, barriers and solutions between the workshop participants and members of the Centre of Excellence for Youth Engagement, which included numerous researchers and presenters.

The point of the experiential exercise was to reverse the normal power dynamic in adult/youth relationships, and allow adults to experience firsthand the barriers many youth encounter when being asked to engage in research. The answers given by the adults are identical to those often given by youth when asked to become involved in research and work with researchers and with adults.

Our challenges in engaging youth in research include: language, the various cultures of research, program, policy advocacy, the need for consistency of research collection versus autonomy for youth participants and populations being researched, and the need for experiential learning versus prescribed training techniques.

The Centre of Excellence is seeking to engage different types of youth in its Centre. Effective engagement, as defined by our Centre, has youth as partners in decision-making, planning and implementation, rather than simply as workers or volunteers to be directed. The term youth refers a broad and varied demographic. The Centre's core partners work with a wide range of young people, and we are attempting to reach all of the demographic. The barriers and challenges are not the same for each group.

First and easiest to engage in research has been post-secondary youth studying in educational institutions heading up our academic research team, wanting to acquire research experience. Academic language, protocols, doubt about the purpose of research are seldom barriers, but the observation is that in meetings it has taken time for the younger members of the academic community to speak as comfortably and freely and as often as senior professors.

The second easiest group to engage has been the 19-26 year-old "activist" youth, working or volunteering with youth or youth-serving organizations. The challenges we face with this group relate to language, culture, purpose and policy. Words like volunteering and community involvement can be highly political. The culture of this group is action-oriented and often adversarial, particularly to those they perceive to have power and authority (academic researchers or program directors).

"There is a constant tension between 'using' youth to gather data and involving youth in the design of the questions, in the collecting of the data, in the analysis of the data, and then use of the data in the design and implementation of programs and projects that feed back into the youth population. The communities we work with will ask, how is this information going to be used? how is this process going to strengthen us? how will we be able to move forward collectively as a community by participating in a focus group." – *Youth from our collaborative electronic work space*

These young people often want to challenge the purpose of research and cite the resistance of youth who are tired of being researched, with no clear payback to those who are its subject. Yet this group will also often use language and cultural practices that are a turn-off to other youth from other demographic groups: words like systemic, intersection or civil society. Some of our younger, high school age researchers have been attacked and humiliated when trying to interview this group.

"A couple of days ago, I contacted someone to do an interview. He accepted and ...as we went through the questions, he became so upset and started asking me why I was doing this, that from his point of view what I was doing was a 'waste of time and money'.....The worst thing was how he made me feel and the way he was talking to me.... it's really sad to realize that there are people (who call themselves 'activist' and 'involved') who don't appreciate what we are doing and the only thing they do is just put you down...just because they think that what they are doing is better? because he's older? because?" – *Youth from our collaborative electronic workspace*

The third group we are looking at is made up of 19-26 year-olds not involved in post-secondary education, but working full time. We wish to ensure their interest in the research work of the Centre because they work with youth and they are youth, albeit older youth.

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Their language is practical, their interests are practical, and they challenge the language, culture and practices of academics and activist youth.

"I get frustrated trying in my head to apply this systematic research to something as unsystematic as youth engagement and the effect that it has on individual people's lives. I just think that you can do all the quantitative and qualitative research that you want, but you'll never be able to capture looks and feelings of people in that way." – *Youth from our collaborative electronic workspace*

The fourth group is young people 12 to 19, both in high school and out. This, in fact, is our primary target group, both as subjects of the research – our primary focus is the engagement of adolescents – and as partners, designers, planners. They are very issue-, project- and action-oriented. The irony of this group is illustrated by the fact that we can hire them as researchers, train them to do research and send them out to do research with their peers without written consent from their parents. However, in order for us to interview them or get them to interview their peers in a university-approved study, they have to get parental consent to be interviewed or participate as research subjects. There is a real irony in needing to get consent from an adult, so that one youth can talk to another about why they are or are not engaged in their society. The problem is compounded when we interview street youth.

We are looking for alternative approaches and types of research, which won't always require consent forms. With the activity level of our core partners and associates, we have enormous opportunities for engaging, interviewing and surveying youth with a more journalistic style approach to data collection, to supplement the traditional, slower academic approach.

There are also some real "turn-offs" for "here and now" adolescents and action-oriented youth running programs where things happen on the fly. Getting consents means a time delay; if a young person is interested and then you put two, three steps between their interest and the activity, you lose participants. The more complicated the process for returning consents, surveys, transcripts, the lower the participation rate. The key ingredients for engaging youth in our Centre of Excellence include being in action on concrete projects, paying attention to the human and relational aspects of our working together, and ensuring that young people have, and see themselves as having, a meaningful role in making decisions. A McGill University study, headed by William Smith from the Office of Research on Educational Policy, reported: "Student engagement is not primarily activity driven: it involves complex relationships between people, activities and ideas."

Our Centre has been successful in getting the university ethics committee to lower its age of consent requirement to youth 16 and under. Also, we've established a Youth Ethics

Committee as a means of counterbalancing the perceived power of the University Ethics Committee as well as ensuring that academically developed tools are "good" experiences for youth.

We are learning how to structure research as a program, and how to understand what types of activities appeal to what types of youth. We are learning how to engage youth in creating research as a program and perhaps even developing a different vocabulary for the activity. We are also discovering the key initiating and motivating factors for youth in engaging in research.

Our vision, for our Centre and our work, includes changing the way research is done, making research accessible to youth, and changing the adults and environments with and in which young people live in order to make them more engaging.

And for those of you who were wondering what happened to the pieces of paper the group posted on the front board…

Dan: "Are you wondering about the coloured piece of papers you filled out?"
Group: "Yes, what are we going to do with them? We've been waiting all workshop."
Dan: "Oh, we had you fill those out, because we thought we might need them today, but we didn't. Don't worry, we'll keep them on file, in case we do one day."
Group: (Laughter)

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C-8

Why Are So Many 9-Year-Olds Unable To Read?

What Can Be Done About It?

by Julia O'Sullivan and Gwen Maguire

Thirty percent of young Canadian children have significant problems learning to read.[1] Who are they? The overwhelming majority come from one of two high-risk groups: children living in low-income families; and children whose language is different from that of the teacher and the school.[2] In schools where most children come from these high-risk groups up to 100% of students may have problems learning to read. These high-risk schools are most likely to be found in the heart of the inner city and in small, rural and remote communities.

It is a common myth that most young children with reading problems eventually "catch up." There is overwhelming evidence that a child's reading ability relative to others his/her age is highly resistant to change after age nine. Indeed, by age nine, a child's reading ability is one of the best predictors available of that child's income in adulthood. Why? Before age nine children are taught how to read in school. After age nine, reading and writing become mediums for learning in school.

By age nine, children who have difficulties in reading start to fall behind in most areas of school work. They simply do not have the literacy skills to learn from textbooks in the different curriculum areas and to demonstrate what they have learned through written language (e.g., essays, written tests). These children are at high-risk for school failure, dropping out, low literacy and chronic under- or unemployment in adulthood. In high-risk schools where most young children have reading problems, it is not only the well-being of the children but the future of the community that is in jeopardy.

The evidence is clear that the reading problems of children in high-risk schools stem from inadequate opportunity to learn.[3] Even before they begin Kindergarten, children from low-income families, relative to children from more affluent homes, demonstrate significant delays in oral language, in awareness about books and print, and in knowledge of sounds.[4] These abilities all influence reading development and are related in part to the literacy environment created by parents in the home. For example, children who are read to frequently by parents demonstrate small but statistically significant advantages when learning to read. Although parents play an important role in their children's reading development, it is nevertheless a supportive role. Ultimately, teaching children how to read and write well is the responsibility of the schools.

Schools take that responsibility very seriously. From Kindergarten through to Grade 3, 40% of instructional time in school is devoted to language arts. Despite that, a significant proportion of children do not learn to read well. Why? Teachers report being inadequately prepared to teach reading especially to children-at-risk.[5] University-based teacher education programs are not known for preparing teachers well to begin teaching reading. Once teachers commence their careers, appropriate continuous professional development opportunities are not in place.

Professional development for the most part still consists of a consultant brought into the school or school board for a day or a half day to talk about "the latest" in reading. Opportunities for follow up and follow through are extremely rare The extent and type of ongoing professional development necessary to build expertise in reading instruction exists in only a handful of schools across the country. The inadequacy of educational opportunities and supports for teachers amounts to an infrastructure problem in our education systems at all levels. The effects are felt most by children in high-risk schools; children who enter the system already disadvantaged; children who suffer the most when they do not receive good reading instruction.

What can high-risk schools do if they want to make a real difference in reading achievement? It is very clear from the literature that there is no reading program they can buy, and no expert they can send for, to solve their problems. If high-risk schools want to make a real difference, they must enhance their own capacity in early literacy education by developing expertise in reading and how to teach it. This takes time and is not always easy.

St. Teresa's LEAD Program

An example of a school that has done it with great success is St. Teresa's School in St. John's Newfoundland. The model developed by that school has been selected by the

National Centre of Excellence for Children and Adolescents with Special Needs as an example of best practice in early literacy education. This is because the model at St. Teresa's is evidence-based, has resulted in permanent capacity for the school in early literacy education, and has produced consistent and substantive effects on children's reading achievement in evaluation research.

St. Teresa's is an inner-city elementary school. Approximately 700 students in Kindergarten to Grade 8 attend the school. Extremely low achievement in literacy led teachers and administrators to decide that a radical new approach to teaching reading was required. Consequently, during the 1998-99 school year, an innovative project was launched in primary reading instruction. An examination of the research on early literacy development and instruction led to the design of a special literacy project, entitled the St. Teresa's Primary Reading **LEAD** (**L**iteracy, **E**ducation, **A**chievement, **D**evelopment) Project. The project began with all students in Grades one and two and the following year was extended to Grade three.

The project involved completely reorganizing the way language arts was taught in the primary grades. Every child is individually assessed at the end of his/her Kindergarten year by the school's reading specialist. Several formal and informal measures of reading are administered individually to determine each child's reading level and to identify the types of reading difficulty children are experiencing. The children's reading is then classified under the Newfoundland and Labrador Department of Education's emergent, early and transitional reader categories. Children are grouped according to reading level and re-grouped across grade level (i.e., children from Grades 1 and 2 can be in the same reading group). Reading instruction for all groups takes place for the first hour and a half each day. All Grades 1, 2 and 3 teachers as well as the reading specialist and the special education teachers teach a reading group. Children from one home room class may be spread through four different reading groups for language arts. Some children also receive additional small group intervention throughout the day.

The reading groups are dynamic so that when a child acquires the skills being taught in one group s/he is moved to the next group. This can occur at any time of year or on any day depending on the growth and development of the child's language ability. The instructional approach to teaching language arts is multidimensional and uses effective strategies from a variety of sources. Children are taught to unlock language using phonemic awareness, phonics and decoding skills. These skills are taught using both systematic instruction and within the context of authentic reading experiences.

Quality children's literature is a large component of the program and children have access to many well-written and beautifully illustrated books at their instructional level. Continuous professional development for teachers is a central component of the model. Teachers meet frequently and identify areas for professional learning. The reading specialist provides professional development or arranges for someone from outside the school to come in and lead sessions for the teachers. Continuous, teacher-led professional development is associated with systematic approaches to instruction across teachers and across reading groups.

The model presented many different challenges for all involved. Teachers were challenged to restructure their classrooms and to alter their teaching styles. Administrative routines had to be reworked and meetings were frequent. The fact that children receive instruction in dynamic groups and by teachers other than their home room teacher presented several difficulties. For example, the issue of how to provide adequate and accurate reporting to parents within the provincial Department of Education framework was a hurdle to overcome. Similarly, parent-teacher conferences had to be restructured to include opportunities for parents to meet with both their child's home room and reading group teachers.

The impact of the program on children's reading achievement has been evaluated systematically by a university-based team of researchers. Each year of program operation, the children's reading has been measured in the fall and again in the spring of the academic year. Importantly, the reading performance of the St. Teresa's children is compared with the performance of children from other inner city schools matched with St. Teresa's on the basis of demographics and reading achievement history. Findings from the evaluations consistently reveal statistically significant and substantive improvements on the reading subtests of the Woodcock-Johnson Psycho-educational Battery for children at St. Teresa's but not at the control schools. For example, after 18 months in the program, children's average percentile rank improved from the 32nd to the 53rd percentile. Findings of this magnitude are rarely reported in the literature.

St. Teresa's model has wide-ranging application, particularly for primary schools experiencing systemic, chronic reading under-achievement. Many such schools are in rural and northern Canada where some of the resources available to St. Teresa's do not exist. However, technology can be exploited to bring these and other resources into these schools in an attempt to increase the capacity of rural and remote schools in early literacy education.

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D-1

Community and Family Characteristics, and Child Health Outcomes

Researching across the boundaries

by Nazeem Muhajarine

Child health is receiving increasing attention at the international, national, provincial and regional levels. However, this burgeoning interest has outpaced policy-relevant empirical research. To advance scientific understanding of the determinants of child health, research is needed that better illuminates the local contextual determinants of children's health, and the multiple pathways through which health is affected. The findings of such research can inform the development of local interventions and policies.

This paper is concerned with a program of research focused on understanding how the characteristics of children and their families, in combination with community characteristics, influence child health. It introduces evidence from three studies investigating family and community attributes on early childhood outcomes. A model showing how the policy, practice, and research domains interact to benefit children and youth follows. The paper concludes with a presentation of the key characteristics of the child health research program of the Saskatchewan Population Health and Evaluation Research Unit.

Study A

Violence During Pregnancy: Family and community characteristics

Violence perpetrated during pregnancy has serious negative consequences to both mother and child. Women who experience physical violence during pregnancy not only have higher incidence of physical and psychological trauma, but also are more likely to have an aborted pregnancy and adverse birth outcomes. Results based on our earlier analysis identified individual level factors for women that made them more likely to experience physical violence during pregnancy. These included: women of Aboriginal ancestry; having a male partner with a drinking problem; reporting overall stress and experiencing specific recent negative events; and reporting frequent interactions with friends or family to have fun or to relax.

However, women who reported that they had friends and family with whom they could talk about private and personal things or get together to relax were less likely to experience violence during pregnancy, indicating that the quality of the social interactions and not simply the quantity makes a difference in having a positive pregnancy experience. Further analysis showed that the types of neighbourhoods that women lived in also mattered. In addition to the personal factors mentioned, we found that women who lived in neighbourhoods with a higher proportion of people with Aboriginal ancestry and higher average cost of homes were at increased risk. On the other hand, women who lived in neighbourhoods with higher median incomes and higher density of homes were less likely to experience violence. Although the results involving neighbourhood factors were mixed and difficult to interpret, taken together, the importance of neighbourhood context to an analysis of physical violence during pregnancy was illustrated in this study.

Study B

Health Care Utilization of Children in the Early Years: Does hospital use by preterm children equal that of term children in the first five years?

Use of health care is an important outcome for children in the early years. We studied whether children born preterm had utilization rates that equaled the rates of term children (defined as "catching up"). If so, when during the first years did this equalization occur? Using a 2-year birth cohort of children and their linked administrative health care data, we found that moderate preterm children (born between 34-37 gestational weeks) did catch up with their term-born counterparts in hospitalization rates, and that this occurred during the fourth year.

This relationship was seen even after accounting for differences in hospitalization rates due to mother's age, family income stability and child's sex. However, children born very preterm (less than 34 gestational weeks) did not catch up with their term-born peers. We also found that while equalization of hospitalization rates occurred between moderate preterm and term children, such event did not occur for number of days spent in hospital between preterm (whether moderate or very preterm), and term children during the first five years. These results showed that children born preterm continue to experience health disadvantages well into the kindergarten years.

Study C

Housing and Neighbourhood Characteristics and Respiratory Illness in Saskatoon Infants

Respiratory illness is a major contributor to overall morbidity among children in the early years. We investigated patterns of neighbourhood characteristics – particularly housing-related – and respiratory illness among children less than two years of age. Respiratory illness was measured in this study as visits to physicians or hospitalizations that had a primary diagnosis related to conditions involving the respiratory system (e.g., asthma, bacterial pneumonia, influenza). Using geographical mapping techniques, we found close correlations between neighbourhood characteristics – proportion of families in low income circumstances, proportion with Aboriginal ancestry, proportion of single parent families, and proportion of housing that needed major repairs – and overall and specific types of respiratory illness in children.

Further analysis of this data will focus on examining specific characteristics of housing in neighbourhoods (occupant density, housing tenure, period of construction) and respiratory illness in children, to try to better understand why children living in some neighbourhoods have higher rates of respiratory illness compared to those living in other neighbourhoods. We will also examine whether the effects of neighbourhood and housing characteristics have a different impact on children who are born small for their birth age (small for gestational age), compared to children born at appropriate size for their birth age.

Linking Policy, Research and Practice

In communities, cities and regions in Canada today, there is an unprecedented level of interest in finding ways to work together to improve the conditions that produce better outcomes for children and youth, and to enhance their well-being. Success (or failure) in this endeavour depends on many things, but in large part it relies on the ability of individuals and groups to share expertise, and to commit to a program of action and reflection at local and national levels to improve the conditions for children. We describe here, a model proposed in Saskatoon that is intended to increase the understanding of the major domains of work and engagement relating to children and youth and how these might relate to each other. The purpose of this model is to engage broad levels and types of participants, and to increase understanding of the mandates of the local participants and relative contributions that each could make to an overall children's agenda.

Our model identifies three major domains of engagement: Public Policy; Program Delivery and Services; and Research. Public policy refers to the set of activities and decisions that set formal expectations, rules and regulations that govern society. Program delivery and services refers to the activities that provide care and advice to and serve individuals and groups. Research refers to the systematic approach to revealing insights, understandings and knowledge. These domains of work do not exist exclusively of each other but relate to one another in identifiable sets of activities.

Take public policy and program delivery and services as an example. The overlapping area of these two domains, where practice influences policy, is advocacy, and where policy influences practice, is best practices. The activities that intersect policy and research can be identified depending on the "flow of influence" or the locus of one's primary domain. The policy that influences research, or if one's perspective or domain is mainly that of policy-making, the intersect may be identified as policy-informed research. On the other hand, if research influences policy, or one's perspective is mainly that of research, the intersect may be seen as policy-relevant research. Intersect between research and practice describes evidence-based practice or action research, depending on one's perspective or primary commitment.

These domains of engagement and their related activities do not exist in isolation of the broader society and environment. The sweeping, circular arrow in Figure 1 depicts the dynamic societal context, which influences, and in turn is influenced by, the activities in the three domains and their intersects.

Child Health Research Program

The key characteristics of the research program on children's health are presented, in summary form, below:

- studies individual-level characteristics in relation to the social and physical context in which families live
- studies consequences of well known adverse birth outcomes (low birth weight, preterm birth, small for gestational age) in the early childhood period
- studies spatial distributions of child outcomes
- uses measures that capture the dynamic nature of social phenomena
- investigates children's use of health care services in the early childhood period
- uses longitudinal designs
- uses primary and secondary sources of data, if possible, in combination
- uses an overarching conceptual model to guide research
- interdisciplinary, multi-site research teams
- involvement of community-based organizations, policy and decision makers, and practitioners
- recognizes overlapping and interacting domains of engagement (policy - practice - research)

Conclusion

We have presented evidence from studies that show children's heath and well-being in early years (including prenatal period) are enormously influenced by the family, neighbourhood and community that they live in. Further research needs to focus on describing the specific ways in which these environments (family and community) mitigate potentially harmful influences from the broader society, while enhancing positive impact on children. The research, however, needs to be linked with policy and practice to create and sustain conditions that are beneficial for children. In this regard, we have presented a model that shows the three domains of activity and how they may relate to each other.

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D-2

Rural, Remote and North of 51

Community-Based Research on Challenges Facing Service Providers Working with Substance Abuse Related Special Needs

by Margo Greenwood, Theresa Healy and Sarah de Leeuw

Life in rural and remote communities of Northern Canada is unique and challenging. This is particularly true of service provision for children and adolescents with special needs. While communities have developed innovative ways to meet the special needs of these children, adolescents and families, there remain a number of obstacles in addressing special needs in regions removed from large urban centres. Nowhere are these challenges more pronounced than when meeting the needs of children and adolescents with special needs associated with substance misuse, including but not limited to Fetal Alcohol Syndrome (FAS) and Attention Deficit Hyperactive Disorder (ADHD).

This paper describes the challenges service providers face working with special needs children and adolescents in rural and remote communities. By exploring their concerns, our objective is to identify and define substance abuse related special needs, as well as to present the challenges and barriers to quality services for those needs.

The UNBC Task Force on Substance Abuse is dedicated to anchoring all of its research in community. The nine goals and objectives of the Task Force include:

- identifying best practices
- defining substance abuse issues in rural communities
- evaluating services for gaps
- analyzing the determinants of substance abuse
- researching current available services and resources.

These can only be achieved by working closely with those most directly involved with them; the community members living and working with the issues. Thus, the UNBC Task Force has a community council comprised of diverse community representation, and is guided more directly by an advisory council of community, agency and academic representatives.

Given the Task Force's commitment to community-based research, an initial task was to travel into communities for information gathering and for guidance on the ongoing research agenda of the Task Force. Researchers began preliminarily key-informant interviews to identify issues of importance regarding substance abuse related special needs and possible prevention strategies.

One of the initial undertakings of the centre was to travel into communities to elaborate and bring alive the goals and objectives of the UNBC Task Force, and to ensure the voices and perspectives of community members were heard. The research focused on, in part, barriers faced by service providers when working with children and adolescents with substance abuse related special needs in rural and remote communities. Focus groups were held in four Northwestern Communities: Terrace, with a population of under 15,000; New Ayianch, with a population of under 1,000 and comprised of primarily Nisga'a First Nations People; Kitimat, a resource dependent community with a population of under 10,000; and Prince Rupert, a coastal community with a population less than 15,000. A total of nineteen people, representing twenty-six service agencies, took part in the four focus groups.

Four questions guided the discussion in each focus group:
1. What are the special needs issues facing your community?
2. What programs, services or actions are really working well to address these special needs issues in your community?
3. What are some of the challenges facing your community with regards to meeting the needs of children and adolescents with special needs?
4. What would help overcome these obstacles and challenges?

In-depth and considered answers elicited highlight the ongoing challenges faced by these service providers.

While the focus group questions regarding special needs issues facing communities were non-specific with regards to the type of special need under discussion, the vast majority of respondents in the focus groups identified substance abuse related special needs as a pressing and growing concern. Issues such as ADHD, FAS/E, and the spectrum of special needs associated with FAS/E, were identified as a major concern in all four communities.

Agencies working with families, adolescents and children did not limit substance abuse issues to alcohol, but included tobacco, "hard and soft drugs" and solvent inhalants.

Special needs related to all types of substance abuse were a growing issue for both service providers and families in rural northern communities. They emphasized that one of the single greatest obstacles in addressing these needs was a lack of direct or targeted funding. In conjunction with a shortage of funding, lack of diagnostic capabilities systematically hindered service possibilities. Even when diagnostic services were made available (locally or by relocating to an urban centre), the lack of flexible diagnoses hindered care and the ability to respond to substance abuse related special needs.

A specific example cited was the IQ diagnosis used in British Columbia to identify FAS: rather than a functional diagnosis, B.C. uses IQ-based diagnostic tools believed by most community service providers to be both limiting and inadequate to fully respond to the realities of FAS. Also noted was the setback borne to communities when programs developed for meeting the needs of children and adolescents with substance abuse related special needs were not sensitive to the cultural realities of the communities in which the programs were being implemented.

The concerns service providers raised regarding service delivery for special needs children mirrored the concerns identified through preliminary key-informant interviews done by the UNBC Task Force on Substance Abuse. This research began from the premise that women's health had to be considered in order to meaningfully address children's health. The research therefore concentrated on a major issue facing the intervention, treatment and prevention of substance misuse, specifically gender and geographic differentials faced by those living in rural, remote and northern communities. The Task Force began a small exploratory study to examine substance abuse problems as identified by women who were the subject of services constructed to help them.

The women identified issues that hindered their efforts to make change in the area of substance misuse. In Prince George, we are fortunate to have active individuals with "street cred" who are also very respected at the national table on FAS. The women centred approach they identified opened the door to exploring issues and developing a comprehensive northern understanding of services needed to prevent FAS: services that would address mothers and thus move towards a preventative model for FAS rather than a reactive model. The issues as barriers to services identified by the women who took part in the key informant interviews were similarly complex and considered as those identified by community service providers. The barriers fell into five primary themes: access; place; identity; context; and lack of resources.

The problems related to place centre on those women from smaller remote communities who made a transition into larger urban centres to access services. This translated into being in a strange environment, with a lack of familiar community resources. Along with any transitional stresses that might be incurred, staying in the home community was also associated with challenges. The realities of living in the north, including climate and geography, both imposed additional barriers and impeded the ability to get to service and resources that may have prevented further addictions issues. A lack of knowledge about possible services translated into a lack of support, and there was the belief that communities have great child sympathy, but women continue to be villainized, particularly women with substance misuse issues. Aboriginal women face racist assumptions, and are thus hindered from accessing services. A lack of Aboriginal specific programs is a secondary challenge to First Nations women seeking services.

Of particular relevance to women in rural remote communities that affected their ability to access services was identity. Their access was framed consistently by a shared history with service providers: because of the size of remote communities, a chain of interconnectedness became, for many women, a chain that imprisoned them from new choices. And women identified a perpetual barrier in their seeking services that might ultimately heal their substance abuse issues; for them to admit their own problems with substance abuse, they risked losing their children. Poverty and racism, in conjunction with policies viewed as punishments, meant a cyclical process that did not address women offering options for positive change.

Throughout the process of identifying challenges faced by service providers, a number of possible solutions were also identified. These became apparent through both an identification of "best practice" models and suggestions of future program and policy implementation. Creative community projects, and partnerships with regional or cultural focus were identified as most successful. There was an extensive desire for renewed linkages and connections between communities and agencies. This interconnectedness was seen to be imperative to rural and remote communities, often separated by great distances and in need of such links. Communities also identified the need for ongoing policy evaluation, with an emphasis on intersecting community-based research with policy development. Finally, communities stated that solutions to the challenges facing service providers in rural and remote communities could in part be dissipated with a translation of research into action, and a linking of community solutions with funding opportunities.

The voices and perspectives of community service providers and women living with addiction issues are the guides in all current research been undertaken at the UNBC Task Force on Substance Abuse. A community-based participatory action research agenda that addresses and identifies both challenges and solutions to substance abuse special needs will be both relevant and meaningful.

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D-3

Early Intervention Services for Children with Special Needs in Canada

Effective Models for Rural, Remote and Northern Regions

by Mary Lyon and Kim Kienapple

The Task Force on Early Intervention is examining early intervention services in Canada with a specific focus on rural and remote areas. The outcome of this work will be to recommend best practices for policy and programs to parents, professionals working in the field, government departments and agencies. Early intervention services are defined as all services providing support to children with special needs, birth to six, and their families. Special needs is used to encompass all children and adolescents who require additional public or private resources beyond those normally required to support healthy development. Services provided to children with special needs and their families vary because models, policy and funding differ among the provinces, territories and the federal levels of government. This is especially the case when the focus is on children from birth through six years of age. Meeting the needs of children from birth to six living in rural and northern communities is additionally challenging because current best practice models do not consider isolation factors.

Method

The Task Force has established a research and development agenda consistent with Health Canada's mandate and in partnership with community members involved in early intervention services. Each of the five functions and related research activities are presented along with a description of the work in progress and expected outcomes.

1. *Collect and analyse information on early intervention services and programs which provide support for children from birth to six with special needs in Canada.* These programmes may be delivered through early intervention services such as early intervention programs, family resource centres, child care centres, early childhood special education services, clinical, health and health-related services.

Data is being collected on the following topics: enrolment in programs and services and prevalence data; legislation; policies; definitions; eligibility criteria; training requirements and programmes; links with other services and information needs of parents/programmes; transition to school; school readiness; and early support for learning at school. A review of international, national programs, agencies and organizations concerned with early child development and early intervention and related policy documents has been undertaken (e.g., OECD, CPRN). As well, a review of provincial programs and services has examined specific characteristic such as auspice, eligibility, evaluation procedures, funding, location, mandate and services.

Common areas of concern among programs have been identified: terminology (early intervention, special needs, family centred, home visits, etc.); professional status; administration; availability of resources; and funding. A document outlining national policy is in draft form; international and national policy reports have been collected; and a pilot survey of early intervention services is completed in Nova Scotia. In addition a grant proposal for funding a national workshop for early intervention professionals has been submitted. Results of the policy review will be available upon completion. The Nova Scotia pilot project will be used as a template for a national study and the results used for programme development by those involved: early intervention programs, family resource centres, child care centres, etc.

2. *Conduct focused research related to models of early intervention relevant to rural and remote areas, outcome measures relevant to evaluations, early indicators/signposts, assessment tools and diagnostic procedures, training needs and models of delivery.* Extensive literature searches have been undertaken by research assistants and community partners on various aspects of these topics. Work is completed for: treatment approaches for children with autism; treatment approaches for children with down syndrome; assessment and diagnostic tools for attention deficit hyperactivity disorder; and, preliminary work for early intervention and reading disabilities preschool program and assessment. Additional work remains to be done on refining the completed reviews for public use and on concluding surveys on rural and remote services, outcomes, and evaluations and training

models. Finished products will be made available on the Centre of Excellence website and upon request.

3. *Provide policy advice.* As the Task Force completes various stages of research, policy recommendations will be made when appropriate. Information on Canadian services and recommendations for capacity building to support young children with special needs in rural and remote areas, models, outcome measures, training, and service coordination.

4. *Generate and communicate information to a wide range of audiences.* Information on training materials and delivery mechanisms, signposts/early indicators/problems and early intervention programs will be prepared for early childhood educators and parents; best practice program templates for provincial governments, programs and training institutes; and resources for parents and programs with a focus on ethnic and linguistic diversity. This information will be disseminated in a variety of ways and through specific projects. Currently, training materials are being identified and developed in three areas: autism, attention deficit hyperactivity disorder and learning disabilities.

In partnership with the Izaak Walton Killam Health Centre and Human Resources Development Canada, a distance education model for children with autism in child care settings will be created. The Learning Disabilities Association of Nova Scotia is examining assessment tools for preschoolers to lower the age of diagnosis and intervention, and Task Force members are working on a similar project for ADHD. In addition, an in-depth presentation of policies, services, agencies concerned with special needs in Nova Scotia, Special Needs Information Service (SNIS), is being prepared as a website with possible application as a model for national delivery.

5. *Establish local and national networks to continue work.* Partnerships with early intervention service providers, provincial and national governments and organizations, families, child-serving agencies (health, education, community) are being developed and strengthened in the process of doing research. Such connections will ensure direct communication of the resource materials provided.

Development Phase of Project

In an attempt to discover who is delivering and receiving Early Intervention services in Nova Scotia, we distributed a survey to all Early Intervention, Family Resource and Child Care programs in the province. Although the surveys varied according to the agency, questions concerning program components, administrative structure, funding, staff qualifications and roles, characteristics of children and families served, and goals and directions were asked. The analysis of the data will result in a comprehensive description of who offers early intervention programs, who receives early intervention services, what services are offered, and future directions for early intervention in this province. The ultimate goal of this component is to develop, in consultation with provincial representatives, a national survey that will provide a comprehensive description of early intervention across the country.

At this point we have received data from 12 of 17 early intervention programs, 19 of 38 family resource centres and 174 of approximately 300 child care centres. The final analysis will feature the data from all the early intervention programs and the family resource and child care centres that provide programming for children with special needs and their families.

A brief overview of the responses from the early intervention programs follows. The reasons for children entering early intervention are varied with no one identifying condition predominating. An average caseload for a program is 28 children and their families (range 5 to 96 children). All programs include children from birth through six years of age. Most programs have a waiting list and the average number of children on the list is seven (range 0 to 31 children). The average time spent on the waiting list is three months.

Service delivery is guided by family service plans in all instances. The early intervention programs encourage families to be involved in all discussions leading to the development of these plans, that families make all decisions and that families must be provided with all relevant information about their child and the services needed and available to themselves and their child. As a result, early intervention providers describe their role as focused on the family and also on the child. Developmental, financial, medical and respite information is routinely provided to families. Home visits are the primary mode of service, although, all but two early intervention programs offered centre-based programming. Part of the early intervention provider's role is community education; thus, time is spent in schools and meeting with community and parent groups.

Given the focus on family and community, it is not surprising that program staff spend between 30 and 70 percent of their time in direct contact with the children. Balancing these two roles is a challenge and program staff report that their most important skills are communication or interpersonal followed by technical (i.e., measurement, activity design and delivery) skills. Knowledge of child development and family policy are the two most important areas of expertise required for program staff. The majority of program staff has post-secondary training in an early childhood education program.

Providing information, services and support to families are identified as the prevalent goal for early intervention programs. As to future directions, concern over funding levels predominates the list. The elimination of waiting lists and the provision of more individualized experiences for both children and families are seen as important next steps.

In more rural areas of the province external programs (i.e., speech pathology, physical therapy) are not as readily available and they should address this.

Combining the information from the three sets of service providers will enable a detailed examination of the characteristics of early intervention providers and recipients. Having accesses to this information should provide the foundation for policy analysis and policy recommendations.

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D-5

Youth-Driven Evaluation

Evaluation of programs FOR and BY youth

by Heather Chalmers and Linda Rose-Krasnor

Youth experiences around evaluation usually involve filling out some boring form at the end of a project or program. In this workshop, we present some innovative ways to get youth engaged in the evaluation process from the start, including ways in which youth can be involved in the design, implementation and reporting of the findings. We also identify some of the unique features of programs for youth and how these characteristics relate to youth involvement in program evaluation.

Research orientations frequently have been characterized as either traditional or participant action-based.[1] In traditional approaches, research questions are generated by the researchers and typically have their origin in theory-testing or previous findings. Researcher objectivity and dispassion are important characteristics and participants are considered as "subjects" or "objects". Methods in traditional research frequently are quantitative, with a focus on meeting the needs of the researchers. Publication of results usually is limited to academic journals, with any subsequent popularization of the results not considered to be the responsibility of the researchers.

In contrast, two research methodologies have been helpful when working with youth and meeting the needs of both youth and youth-oriented programs. Utilization-focused evaluation, the first of these methodologies, is based on the premise that evaluations should be judged by their utility and actual use of the end results.[2] The focus in this type of evaluation is on the intended use of the findings by the intended user or, in this context, how the results can be used by the youth themselves. This methodology offers some guidance to investigators who work with youth by assisting the users (youth) to determine what kind of evaluation they require to meet their needs.

Participatory research is a second research approach that is helpful in youth-oriented research. This methodology is defined as a process of developing self-conscious inquiry that empowers people to take effective action toward improving conditions of their lives.[3] It balances research, action and education. Participatory research involves the active involvement of, and often control by, those people who would be among the "objects" or beneficiaries of the research.[4] Both utilization-focused evaluation and participatory research contribute to the empowerment and engagement of youth in the research process, given that "ownership" for the research process is by the youth themselves.

There is frequently tension between traditional and participant/action-based approaches to research. In the following, we consider four sources of this tension: standardization (participants get the same questions asked in the same way) versus individualization (questions are asked based on interviewee's experience), inside (youth or those working with youth) versus outside (academics) agents driving the research, and the development of questions from theory (literature) versus from youth themselves (experience). Further, the results of evaluation within the traditional approach often end in a research report that may not be in a format that meets the needs of the youth and not be published until several years later. In a participatory approach, the results are immediately integrated into the program to enhance it's success. The focus of the evaluation is meeting the needs of participants and end users of the findings, rather than meeting the needs of outside researchers.

Youth involvement in the research process can allow for participant action, even though elements of the traditional approach may be incorporated into the evaluation. For example, rigour can be applied to the development of any measurement tools, as well as in the collection and analysis of the data. Without this element, validity of results may be compromised. An important aspect of a participatory approach is education. Educating the youth about why rigour is important for validity and educating adult investigators about how to get the "best" responses from youth is critical to the success of the evaluation. Having youth be part of the research process can assist researchers to determine the most appropriate methodology (qualitative vs. quantitative) and the most effective way to ask questions.

The varying views of youth about traditional methods of data collection can be illustrated in comments provided on a recent survey of youth, in which we were exploring personal and relationship correlates of youth engagement and sense of social responsibility. Youth were asked to comment on the survey itself. Some responses were: "It made me think about how I lived my life and helped me see what I want to change about me"; "I feel that you can't really know a person or how they feel unless you talk to them"; "I like the opinion ones [questions], not the fact ones"; and "It made me feel a little annoyed because the questions were pretty much the same". These comments indicate that youth want to be asked their opinions. They also illustrate the challenge of balancing measurement validity with the risk of annoying youth with repetitive or seemingly "irrelevant" questions. If balance is not achieved, we may fail to obtain quality responses and meaningful results.

There are several significant barriers to involving youth as an equal partner in the research process. These include difficulty in achieving mutual recognition of the skills each person brings to the team and language differences. The first difficulty is recognizing that both researchers and youth bring a unique perspective to conducting youth research. The key to overcoming this barrier is respect. Youth and adults need to respect that they both have expertise and that, although the types of expertise differ, each makes an valuable contribution.

Language incompatibility is a second barrier. The language of adults and youth may not always be the same. Significant effort must be made to ensure that both youth and adults understand each other. When beginning a collaborative research process, it is important to ensure that adults and youth spend adequate time talking with each other, soliciting each other's opinions, and checking to make sure that there is a reciprocal understanding of what each partner views as the primary research question.

Other barriers include differing goals and objectives for the project, memories of difficult past experiences working with each other, differing restrictions that researchers and youth must work within (e.g., ethics, bureaucratic requirements) and a differing sense of urgency. Surmounting these difficulties is critical for program success and an effective working relationship. Each of these barriers can be overcome with strong communication, reciprocal education, and mutual trust and respect. Establishing a common end product or goal for the project, and then working toward that common goal, are key to the development of trust. If both youth and adults are committed to the same goal, the likelihood of overcoming these barriers greatly increases.

Youth have a tremendous amount of creativity, energy, insight, and enthusiasm that can benefit both traditional researchers. Developing a mutually respectful partnership takes time and energy by all parties and can sometimes be challenging. However, if both youth and adults focus on a mutually agreed upon goal, open their minds to new perspectives on conducting research, and work as equal partners, the evaluation of youth programs can be a rewarding experience for all partners.

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D-6

Kitchen Conferences

An Electronic Forum on Parenting for Rural Canadians

by Jessica Woolfrey and Dianne Rogers

The Canadian Institute of Child Health (CICH) is dedicated to promoting and protecting the health, well-being, and rights of children and youth through monitoring, education and advocacy.

The CICH is a non-governmental, not-for-profit, charitable organization governed by a well-known and respected volunteer Board of Directors from across Canada and supported by an Advisory Council with multisectoral expertise. The staff is comprised of six directors, twelve support staff and consultants.

For 25 years, the Institute has provided a strong, effective voice for children and youth by:
- linking research to clinical and parenting practice;
- increasing the sphere of influence on the health, well-being and rights of children and youth to private, public and non-governmental sectors;
- increasing the engagement of parents and youth in programs and policies;
- working with governments and industry to promote and protect children's health, well-being and development.

The CICH focuses their work in five major areas of interest:

1. Healthy Pregnancy and Childbirth (e.g., National Breastfeeding Guidelines for Health Care Providers)

   We improve the quality of prenatal, maternal and newborn care, particularly to decrease the incidence of low birth weight babies. We also manage postpartum parent support programs and encourage hospitals to provide family-centred care at birth.

2. Healthy Child Development (e.g., Centre of Excellence for Early Child Development)

   We promote positive family mental health through information and programs designed to improve parenting skills, prevent child sexual abuse and demonstrate how children and seniors can enrich each other's lives.

3. Monitoring Children's Health (e.g., The Health of Canada's Children: A CICH Profile)

   CICH is the only national organization which maintains a comprehensive statistical profile of children's health (birth-19). This information is an invaluable national resource for advancing progress and setting priorities so that our governments, our communities and our employers can take positive action for children's health.

4. Healthy and Safe Environments (e.g., Still Home Alone)

   CICH is dedicated to the creation of a protected environment for children including safer playground equipment, car seat legislation and addressing environmental contaminants with a specific focus on children.

5. Speaking Out (e.g., Say it Right)

   We are a dedicated voice for Canada's children. By improving our understanding of the special challenges facing children today and by taking preventative steps to safeguard children's health and well-being, we ensure that these needs are heard by decision makers so that children always remain our highest priority. We also look for opportunities for children and youth to speak out for themselves (e.g., Youth-to-Youth).

A new and exciting project that the Institute is currently developing is called Kitchen Conferences: An Electronic Forum on Parenting for Rural Canadians. This technology-based parenting series is a forum for families and ultimately for a community of learners across Canada with a shared interest in parenting and child development. It consists of eight online, "real time" interactive parenting sessions (modules) that include a variety of components such as guest speakers and opportunities for debate and discussion on the topic/issue presented. These sessions will be webcast through the Internet.

The first half of the webcast will be a 30-minute presentation delivered by an expert in the field of a specific topic area. This presentation will be delivered in a parent-friendly format and created from the most valid, up-to-date information. The second half of the module will be interactive. The families participating in the live webcast will be able to email questions to the presenter for an immediate response. Due to time constraints, not everybody will be able to get their questions answered. Therefore, the website will be available as a secondary source of information containing all questions asked throughout the live webcast, the response given, frequently asked questions and their answers, support group links, archived webcasts and all background research used to create the module.

The main objectives for Kitchen Conferences are:
- to link parents in communities with evidence-based, consumer friendly and practical parenting information
- to create a learning community that provides support both parent-to-parent and through qualified health care professionals
- to provide valid information reviewed by qualified child and adolescent development experts
- to raise awareness of the many uses of computer technologies as avenues for knowledge development
- to increase skill in using technology to search for information and to learn how to evaluate this and other parenting forums.

The partners that are working in collaboration with the Canadian Institute of Child Health on Kitchen Conferences are Industry Canada, Canadian Library Association, Canadian Public Health Association, AOL Canada and Human Resources Development Canada.

The target population – parents, health care providers and caregivers – has been involved in the development of Kitchen Conferences since the beginning. They have participated in the early research of this initiative, are playing an active role on the project Advisory Committee as well as in the evaluation portion of the project. They have played an integral role in helping structure this series appropriately to meet the needs of our target population.

January 2001 marked the launch date of the pilot for Kitchen Conferences. Nutrition is the module selected to be shown to the pilot group. The pilot group consists of 5-10 families from each of Canada's provinces and territories and will be gathered at their local Community Access Program sites and joined by a local facilitator to view the pilot module, nutrition. The facilitators responsibility includes conducting a pre- and post-survey for the evaluation piece as well as instructing the group how to maneuver through the website, how to watch the webcast and how to ask the expert questions and get an immediate response.

In February 2002 the pilot will be reshown to mark the beginning of the parenting series and the remaining seven will be webcast over year 2002 on a national basis. The target audience for the remainder of the project will be Canadian families directly involved in the sessions nationally, and health care and services providers.

Topics for the modules were selected based on a Canada-wide survey that was distributed to 400 families (77.3 % response rate). The featured modules include nutrition, positive parenting, play, children's environmental health, breastfeeding, child care, safety and injury prevention, and family relationships.

The creation of each module is a multi-step process. The draft content is first created by an Education Specialist in a research paper format using only evidence-based information. The research paper is then reviewed by a sub-advisory expert committee (there is an expert committee for each module). The suggested revisions are incorporated and reviewed for a final time by the Project Advisory Committee. The research paper is then presented to the Productions company who is responsible for the creation of the webcast. The research paper is used to create a parent friendly (lower literacy) webcast.

The final product will be the first series of eight modules and a website that will be continuously updated contain archived webcasts, research on each of the topic areas and contact information (support groups).

Expected outcomes include:
- New and interactive parenting tools for Canadians
- Increased numbers of parents accessing practical parenting information
- Increased parent learning through peer and qualified health care professional support
- Increased availability of credible parenting information to parents
- Increased awareness of the use of computer technology as an avenue for parenting knowledge development
- Increased computer skills of Canadians through access and implementation of online parenting information
- Increased capacity of communities to utilize technologies for health promotion and injury prevention.

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D-7

Communication and Literacy Consequences of Otitis Media among Aboriginal Children

Preliminary Directions for Prevention and Culturally Appropriate Assessment

by Alan D. Bowd

The literature concerning the effects of otitis media (OM) and conductive hearing loss on auditory skills, language development, social development and other aspects of children's behaviour is extensive. However, the evidence regarding these issues remains controversial and data for Aboriginal Canadians are incomplete and sketchy.

Otitis media (OM) is a generic term including the acute condition (AOM, characterized by rapid onset with pain and fever) and chronic otitis media (COM, an inflammatory process damaging the mucous membranes and bone). Otitis media with effusion (OME), involves fluid in the middle ear. Chronic suppurative otitis media (CSOM) involves chronic infection, a non-intact eardrum and discharge for at least two weeks. AOM and OME typically result in transient conductive hearing loss, however, CSOM may cause sensori-neural hearing loss.

This review examines research relating to the health and educational consequences of OM for the Aboriginal children of northern Canada. The high incidence of OM among these children is well known with considerable speculation about underlying causes. Most prevalence data comes from studies employing limited samples. The World Health

Organization has estimated prevalence rates among Inuit for COM of 12%-46% and for Native Americans of 4%-8% .

Methodological difficulties characterize research in the field. Studies report incidence rates for limited samples, use varying definitions and diagnostic/assessment tools and employ correlational designs. The field is interdisciplinary, dealing with cross-cultural issues and drawing on theories and methods from medicine, public health, education, psychology and anthropology.

Prevalence

OM prevalence data for Aboriginal Canadians are limited. Estimates are based on studies employing different definitions of OM and including children of different ages. Inuit and Australian Aborigines have the highest rates (between 12% and 45%), with estimates for Native Americans ranging from 4% to 8%. Among non-Aboriginal Canadians the rate is less than 1%.

Wide variations exist between communities. Prevalence is highest among: Alaska Inuit (30%-40%); Canadian Inuit (7%-31%); Australian Aborigines (12%-33%); Greenland Inuit (7%-12%); and Native Americans (4%-8%). Some researchers have observed an increase in AOM and a decrease in COM among the Inuit over the past decade. (No reference was made to deafness, otorrhea or chronic ear disease in the writings of surgeons working in the Arctic during the first half of the nineteenth century suggesting that they were uncommon among the Inuit.) For First Nations children, prevalence of COM is often between 5% and 6%. For non-Aboriginal children the rate is less than 1%. Data for American Indians are extremely limited. A rate between 4% and 8% appears most likely, more than 4 to 6 times that observed in the general U.S. population.

Prevalence of COM among Australian Aboriginal and Inuit children is alarmingly high. Both peoples lived traditionally in isolated communities in harsh environments, surviving in the past on a nutritious natural diet. Both have a similar histories of acculturation, introduction of previously unknown diseases, alcohol and tobacco, and a diet high in carbohydrates. Both have recently experienced increased urbanization. The only significant environmental difference is the climate. The ear disease prevalent among Inuit and Aborigines is the almost certainly the same.

Hearing loss attributable to Chronic Otitis Media

CSOM is associated with negative pressure within the middle ear and a pumping action of the eustachian tube opening and closing. Chronic perforation of the eardrum may develop and organisms may enter the middle ear through the ear canal resulting in secondary infection and complications.

Hearing loss may range from fluctuating hearing levels associated with infrequent acute attacks, to damage to the eardrum and bones of the middle ear or sensori-neural loss in chronic cases. This usually occurs during the period of language acquisition, for which hearing is vital, and later literacy learning, for which language is vital.

The rate of significant hearing loss for adult Inuits in Quebec has been put at 44%, while for Aboriginal adults on reserves and in settlements 39% of disabilities have been related to hearing. Hearing loss is the most common health problem of the 7000 Inuit living in northern Quebec.

Etiology and Risk Factors

The pathogenesis of OM is complex. The most important factors are developmental: in infancy the eustachian tube and the immune system are immature and exposure to upper respiratory tract infection frequently results in OM.

- Children are most likely to develop OM in infancy. OM incidence peaks between 6 and 18 months, but infants who experience the initial episode at an early age are at 2 to 8 times greater risk for COM.
- Males are at higher risk for AOM and OME, as is true of most infectious diseases in childhood. The ratio is probably less than 2:1.
- Researchers have noted the association between OM and ethnicity, but it is difficult to interpret because of correlated socioeconomic and environmental variables
- Children in homes where parents or siblings have a history of OM are at higher risk. However, the contributions of genetics and environment remain entangled.

Several complex aspects of the environment (e.g. socioeconomic status) are risk factors, along with quite specific elements (e.g. use of pacifiers). These are not independent and are associated with genetic and constitutional elements.

- The relationship between socioeconomic status (SES) and OM is ambiguous. Crowded living conditions, poor sanitation and inadequate access to medical care correlate with recurrent AOM.
- There appears to be no relationship between birth weight or gestational age and OM or OM duration.
- Communities in which traditional hunting was maintained and breastfeeding widely practised have lower prevalence of COM. Change from the traditional high protein, high fat diet to a high carbohydrate diet correlates with increased prevalence of OM. There is abundant evidence that breastfeeding reduces the risk for OM and a greatest degree of protection is conferred on infants breastfed for at least 4 months.

- Limited evidence suggests an association between the use of pacifiers and AOM. Sleeping prone with bottle feeding has been linked to AOM.
- Passive exposure to cigarette smoking is linked to increased risk of OM. Approximately 77% of Inuit women and 62% of adolescents smoke. (No research was located examining wood smoke exposure as a risk factor for OM).
- Risk factors associated with daycare attendance include the type and size of daycare, the age at enrolment, the degree of crowding and hygiene practices. Risk of AOM and OME also increases with the number of siblings in the home.
- The incidence of OM is highest in winter and lowest in summer. No studies were located confirming a seasonal link in the Arctic.
- Breastfed infants with exposure to higher levels of organochlorines in breast milk were at higher risk of AOM, although bottle fed infants remained at greater risk.
- No studies were located examining an association between OM and maternal alcohol consumption during pregnancy. However, a large literature addresses fetal alcohol syndrome (FAS) and fetal alcohol effect (FAE). FAS and FAE are frequently characterized by structural changes to the outer ear, however no study linking FAS/FAE with middle ear anomalies or OM was located.
- Recurrent AOM and OME are more prevalent in communities where risk factors are present but with less access to medical care.The relationship between remoteness and access to medical care requires further investigation..

Long-term effects

Children with a history of COM score lower on measures of vocabulary, language, IQ and reading and they tend to have more academic difficulties. A history of OME in early childhood appears to influence language development, however this requires further study. Relationships between OM and behavioural and attention deficits, as well as language-related difficulties have been suggested. These should be interpreted with caution. Children with language problems often react to frustration with aggression, withdrawal and inattention in school.

Treatment of Otitis Media

Antibiotic treatment of AOM is routine. However its use with Aboriginal children is not always successful because of failure to comply with directions. Treatment in northern Canada is difficult because of isolation, lack of medical resources and cultural/linguistic factors. In northern Quebec, OM is usually diagnosed by nurses and treatment prescribed according to a protocol prepared by physicians and pharmacists. Since the latter do not see the patient, treatment failure frequently occurs because of delays between doses or ceasing treatment before ending the prescription. Treatment failure relates to communication problems, patients' failure to comply with advice and reluctance to ask questions.

Aboriginal values are more present-oriented and lack the preoccupation with time characteristic of non-Aboriginals. However, public health programs stress future effects of risky behaviour rather than immediate consequences. Aboriginal peoples share belief systems of harmony, rather than conquest over nature, and cooperation rather than competition. Community support must be enlisted in health services delivery in the presentation of disease prevention without employing metaphors like "battle" and "struggle." The development of effective services must be at the community level.

Some researchers have argued that the medical disease model separates the individual from the environment. Physical and cultural data are not accessed by the clinician, and when illness is related to environmental conditions, treatment is limited to symptoms. Traditional knowledge and practices of indigenous peoples should inform public health and medical practice in the treatment of OM.

Approaches to Prevention and Intervention

Risk factor amelioration due to medical advances along with community-based public health programs are the keys to preventing OM and hearing loss. However, research regarding the effectiveness of risk factor modification is limited. Health promotion should target breastfeeding, immunization, nutrition, hygiene, housing, overcrowding and access to clean water. Primary health care workers need training and equipment so that prevention of OM is integrated with primary health care in the north.

The Family-Professional Partnerships Model

The prevention and management of OM requires family-centred care that is culturally and linguistically appropriate. However, research suggests that health care professionals believe they should retain final authority concerning treatment, in contrast to parents who believe the decision rests with them. It is essential to take account of families' values and belief systems.

The majority of Canadian Aboriginal mothers do not breastfeed beyond early infancy. Education about breastfeeding could be provided by having young parents speak to both male and female junior high school students about the immediate benefits of breastfeeding, as well as its implications for OM.

Strategies to develop and enhance communication and learning in the family

Children experiencing hearing loss, depending on its extent and the age of the child, sometimes demonstrate difficulties in the use of oral and written language. Strategies to enhance learning for children with conductive hearing loss have been used in schools for several decades, but few exist designed for parents of preschool children and infants. Fewer interventions are culturally sensitive and have been field-tested or objectively evaluated.

Information for parents is posted on the Internet by the American Speech-Language-Hearing Association, the Canadian Pediatric Society and Health Canada. Materials are organized around three basic questions: How are ear infections treated? Can ear infections cause hearing loss? What can parents do? However, the Internet is not yet represent a significant means of communicating with families in isolated northern communities. Materials for parents likely exist locally and are not widely distributed. However none were located for Aboriginal families. No evaluation research was found dealing with the effectiveness of parent education for OM.

Strategies to enhance learning and communication in school

The high teacher turnover rate in remote communities affects children who are deaf and hard of hearing. Many teachers have little classroom experience and may not recognize signs of learning difficulties for Aboriginal students. Their familiarity with instructional modifications is also likely to be limited meaning that in-service training is essential. The high turnover rate implies that training be offered regularly or included with schools' induction programs. (Few materials were located designed specifically for use by teachers with Aboriginal students.)

Adaptations of instructional approaches and curricula should take account of the classroom practices of Aboriginal teachers and their pupils. The behaviour of Inuit teachers in Nunavik is different from those of non-Aboriginal teachers. Rather than the typical question-answer sequence in which the teacher is perceived as the authority and as an orchestrator of interaction, Inuit teachers focus on group participation. Inuit teachers described their role as a facilitator of student interaction, cooperative behaviour and respect. These should be considered in developing culturally appropriate classroom activities and materials.

Simple classroom modifications for children with mild hearing loss include seating the child close to the speaker, getting the child's attention before speaking, speaking clearly with normal intonation, repeating important words and frequent checking as to whether direction have been understood. These adaptations and ways of reducing background noise have appeared in pre-service and in-service special education material for the past two decades.

FM amplification in Inuit classrooms improves speech intelligibility, on-task and attending behaviour for students with hearing loss and students with normal hearing. Positive consequences of classroom amplification have also been reported for Australian Aboriginal children with hearing loss and a history of OM, although expense is often a prohibitive factor in remote areas.

Strategies that facilitate language usage in all young children are recommended for teachers working with children having OME. (However, some of these are culturally inappropriate.) They include encouraging conversation, speaking directly to the child's face, asking children to elaborate on their input, reinforcing auditory information with visual information, and using games and stories with repetition. Reading and activities requiring careful attention to auditory information have been claimed to facilitate listening skills.

Future work in this area

- Limited documentation of prevalence rates in Aboriginal communities needs to be validated by a comprehensive investigation. Systematically collected data from a regionally and culturally representative sample of communities would provide more accurate estimates.
- Further study is needed where risks identified in non-Aboriginal settings have been generalized to Aboriginal societies. Risk factors may exist in Aboriginal communities that have been excluded in studies of non-Aboriginals. The role of maternal alcohol ingestion, FAS and FAE have not been explored and merit consideration.
- Research is needed to on the extent of treatment failure, contributing cultural and linguistic factors, and to evaluate modifications.
- Culturally-sensitive programs targeting breastfeeding, immunization, nutrition, hygiene and smoking should be implemented and evaluated.
- Programs promoting healthy practices, establishing good language learning environment in school, and collaboration with families in the management of OM and should be implemented and evaluated.
- Research is required regarding the content and delivery of teacher in-service education along with the knowledge and classroom practices of teachers in Aboriginal communities.
- Some programs developed outside of Canada may be adapted to be culturally appropriate in Aboriginal classrooms. The effectiveness of interventions needs to be studied.
- Research is needed regarding modifications teachers of Aboriginal children are aware of and actually use, as well as the effects of these on children's speech and language.

The investigation of OM and subsequent hearing loss among Aboriginal children is a complex undertaking. It draws upon the methods and constructs of several disciplines and involves work in communities undergoing rapid acculturation and experiencing acute social problems. However, there can be little doubt as to the importance of this research and its beneficial applications in Canada's north.

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D-8

Engaging Francophone Youth in their Communities

by Gino LeBlanc

Presented by Chantal Berard and Martin Latulippe

The Francophone and Acadian communities have recently made an effort to expand their scope of action beyond the development of so-called traditional issues, such as education or linguistic rights. After having recently built the bases of an economic development structure in Francophone communities, the health field is no doubt the next issue that will be targeted for development by the Canadian Francophonie.

The work that the Fédération de la jeunesse canadienne-française (FJCF) wants to take on, in collaboration with the Students Commission and the Centre of Excellence for Youth Engagement, is part of an effort to better understand the issue of engagement in a Francophone minority setting, but also is to develop programs that will promote, in the community infrastructure, the capacity to foster engagement and improve the health and quality of life of Francophone communities. Therefore, there are three main areas in our partnership with these two groups.

First of all, we seek to better understand the state of affairs and of knowledge on youth health and the psychosocial elements that can serve as barriers or as catalysts for youth to get engaged in their Francophone community within a minority setting. We then want to evaluate the existing Francophone youth programs, particularly those which gravitate around the FJCF network and its members, with the ultimate goal of improving those programs based on the findings of our own research as well as those of the Centre of Excellence for Youth Engagement. Finally, it is important for us that this project contribute to mobilize communities towards a greater ownership of the health and engagement of youth by the whole community. Francophone community organizations have documented the importance of seeing communities truly take ownership of health issues in a global perspective, as defined in the following section.

The topic of health in French in a minority setting is just beginning to be articulated in the wide majority of Francophone communities. The Fédération des communautés francophones et acadienne (FCFA), at the International Francophone Conference of Health Sciences held in Moncton in June 1999, noted that: "It is time for a positive mobilization behind a common goal, among Francophones, to give to our people, all our people, the best health services possible, and all the institutions necessary for development."

Within the framework of this FJCF and Centre of Excellence for Youth Engagement project, the workers intend to address the issue of health by using a wide and holistic definition of health for these communities. When we speak of a youth's engagement in his or her community, we are also speaking of this youth's psychological health, their self-esteem, their place in the community as well as a series of life skills that relate to the daily life of a youth living in a minority setting.

Defining health for youth in a minority setting

In the initial works sponsored by the Fédération des communautés Francophones et acadienne (FCFA) it was already the goal of researchers and representatives to postulate a broad definition of health for our communities. A study of four French-language community health centre models in Canada, completed in June of 2000, established a definition of health which lends itself well to the work we wish to endeavour on youth engagement and life skills.

This study noted that, "According to the vision of health adopted for this study, factors such as education, income and personal autonomy influence the quality of life and the health of individuals. Health is not solely determined by institutional care: prevention and promotion play a priority role to improve the health and the quality of life of a population." Such an approach also supposes a multidisciplinary group of health service providers, since all facets of a person's life are affected. We know that the development of autonomy in youth must emerge through places and opportunities where they can be engaged and heard in their community's development and decision-making arenas.

In another globally reflective essay on the issue of health in a minority setting written in the context of its Dialogue project, the FCFA insists on the fact that we must use as broad a framework as possible to define the parameters of health for Francophone and Acadian communities. It states that "The Francophone population is over-represented in the groups likely to suffer from poor health. This situation requires a revision of traditional approaches to health. For example, we know that health is not solely determined by institutional health care, that an increase in spending for official health services does not necessarily improve the health of the population, and finally that prevention must become a priority to improve health and quality of life."

We adhere to these statements. Our work on youth engagement, based on these holistic definitions of the concept of health for individuals and communities, will allow us to bridge important gaps in our knowledge regarding the health of youth in minority settings and their needs. If we take the time to properly define the concept of health, it's because we understand our work with the Centre of Excellence for Youth Engagement to come from a logic of empowerment by and for youth in Francophone communities, and moreover through the lens of improving the health of our communities.

We are truly fortunate to collaborate with the Centre of Excellence for Youth Engagement. We have shared several of their surveying and analysis materials and applied them, with the help of researchers from Francophone minority settings, to the linguistic and cultural elements that interest us.

While it is crucial to begin this research to determine the status of health and engagement in Francophone youth, it would be hazardous not to complement our efforts with a process to correct the problems, mobilizing and sensitizing the community about the advantages of youth engagement for their own health as well as that of the general Francophone community. It will be important to take into account this element in future phases of the project, when it is time to elaborate or issue recommendations for policy, structure and program change.

The Fédération de la jeunesse canadienne-française has been a dynamic partner of the FCFA from the onset, working to provide better health resources to youth in minority settings. Youth who are in good health both mentally and physically are youth who are then able to get engaged and active in the development of Francophone communities in Canada. The establishment of a collaboration as proposed by the current partnership between the Centre of Excellence for Youth Engagement and the FJCF is a major development for the field of health in the Canadian Francophonie.

The theme of engagement in the context of Francophone minorities surpasses the problem of a youth's place in decision-making structures of society or of the value of youth and their projects. The engagement of a youth in his or her Francophone community is a sine qua non condition for that community's capacity to survive and for the survival of all Francophone and Acadian communities across Canada. We can already note that this engagement does not happen without certain obstacles for the youth and that a minority status presents particular challenges. The opportunity to work with the Centre of Excellence for Youth Engagement in the years to come is a chance we cannot miss and we look forward to many future developments.

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